

Notice of Independent Review Decision

**DATE OF REVIEW: 02/11/2011**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Bilateral L4 and L5 transforaminal epidural steroid injection (ESI)

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Uphold the original denial as issued. There is insufficient information or conflicting information within the two medical patient examinations provided. There is no specific date at which the prior epidural steroid injection was given. There is no specific objective documentation for the diagnosis supporting the first injection that would meet the *ODG* criteria. The patient examination findings reported on the 12/10 report and the 11/10 report differ significantly. At this point in time, criteria to overcome the original denials for preauthorization are not evident

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records Received: 17 page fax 1/24/11 IRO request, 25 page fax 1/24/11 URA response to disputed services including administrative and medical records.

- Adverse Determination letter, 11/10.
- Appeal/Reconsideration Resolution letter, 12/10.
- Patient IRO Request Form, 01/11.
- Company request for IRO form.
- Signed confirmation page.
- Patient follow-up examinations 11/10, 12/10.
- 03/04/08. Lumbar MRI. Impression:
  1. Five lumbar vertebrae are noted for purposes of this exam.
  2. Normal lumbar lordosis and alignment.
  3. Normal conus medullaris and cauda equina.
  4. Mild loss of disk space height at L4-5 with nuclear dehydration. There is central and left lateralizing protrusion. This measures approximately 1.3 cm transverse and 0.5 cm AP dimension. There is compression of the ventral thecal sac and lateralization to the proximal left neural foramen. Correlation recommended with regard to possible left L5/L4 radiculopathy. There is mild facet degeneration.

At L5-S1, there is mild loss of disk space height with nuclear dehydration. No focal protrusions are noted. Asymmetric spondylosis is noted in the left neural foramen with a mildly narrowed left neural foramen.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The medical record from the treating provider, dated 11/10 indicates the patient had a two-week period of recurrent radicular symptoms despite greater than 50% overall improvement from an initial positive response to the first transforaminal injection. Past conservative measures including physical therapy, nonsteroidal antiinflammatory medication, and muscle relaxants failed to control symptoms. The patient has documented findings on examination supporting a radicular pathology. MRI findings are consistent with stenosis, either central, lateral recess, or foraminal, likely causative of the radicular pathology. There are no positive Waddell signs or evidence of psychosocial pathology that would

preclude performance of the recommended repeat transforaminal injection procedure. Fluoroscopic guidance is indicated to assure proper placement of the steroid and optimize outcome. The patient has not had over three injections in the prior 12 months.

The patient, when seen on follow-up examination, had notation that differed from the first examination. The next examination indicated that the patient had seven months of greater than 80% relief after a selective left L4 and L5 nerve root sleeve block. She had returned with pain and a positive straight leg raise, decreased sensation in the L4 distribution, and pain on flexion. There was also noted a loss of reflex (not specified). There is a significant disk herniation compressing the left L4 and L5 nerve roots (not noted in the MRI two years earlier and no apparent recent MRI).

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

Uphold the original denial as issued. There is insufficient information or conflicting information within the two medical patient examinations provided. There is no specific date at which the prior epidural steroid injection was given. There is no specific objective documentation for the diagnosis supporting the first injection that would meet the *ODG* criteria. The patient examination findings reported on the 12/10 report and the 11/10 report differ significantly. At this point in time, criteria to overcome the original denials for preauthorization are not evident

**ODG:** Rationale from the *ODG* relative to epidural steroid injections, therapeutic (*ODG* Online 2011) is utilized. These criteria are included below for completeness to this report.

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***ODG* Epidural Steroid Injection, Therapeutic (*ODG* Online 2011):**

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis although ESIs have not been found to be as beneficial a treatment for the latter condition.

Short-term symptoms: The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months ([Armon, 2007](#)). Epidural steroid injection can offer short-term pain relief, and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function or return to work. There is no high-level evidence to support the use of epidural injections of steroids, local

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anesthetics, and/or opioids as a treatment for acute low back pain without radiculopathy ([Benzon, 1986](#)) ([ISIS, 1999](#)) ([DePalma, 2005](#)) ([Molloy, 2005](#)) ([Wilson-MacDonald, 2005](#)). This recent RCT concluded that both ESIs and PT seem to be effective for lumbar spinal stenosis for up to 6 months. Both ESI and PT groups demonstrated significant improvement in pain and functional parameters compared to control, and no significant difference was noted between the 2 treatment groups at 6 months, but the ESI group was significantly more improved at the 2nd week ([Koc, 2009](#)).

An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy ([Staal-Cochrane, 2009](#)). Recent studies document a 629% increase in expenditures for ESIs without demonstrated improvements in patient outcomes or disability rates ([Devo, 2009](#)). There is fair evidence that epidural steroid injection is moderately effective for short-term (but not long-term) symptom relief ([Chou3, 2009](#)). This RCT concluded that caudal epidural injections containing steroids demonstrated better and faster efficacy than placebo ([Sayegh, 2009](#)).

## Criteria for the use of epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see *AMA Guides, 5th Edition*, page 382-383 ([Andersson, 2000](#)). Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.

( ... )

(7) Therapeutic phase: If, after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain or new onset of radicular symptoms. The consensus recommendation is for no more than 4 blocks per region per year ([CMS, 2004](#)) ([Boswell, 2007](#)).

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections, as this may lead to improper diagnosis or unnecessary treatment.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)