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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 05/16/2011

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified) Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal lumbar epidural or sacral steroid injection, single level

REVIEW OUTCOME

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

should be: Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male employee who sustained an industrial injury to the low back on xx/xx/xx when picking up pieces of wood. He developed left leg symptoms. His history includes a lumbar surgery in 1985 for left leg pain with good results.

According to the initial examination of March 9, 1998 a recent MRI showed he had a right hemilaminectomy and enhancing fibrosis with narrowing of the right L5-S1 foramen and a lateral disc bulge compressing the right-sided root. His right-sided leg symptoms have not been improved. He is 5'6" and 204 pounds. He has chronic lumbosacral syndrome with right lumbar radiculopathy. Injections and imaging are recommended.

Injections were not helpful per report of April 6, 1998. PT was tried and additional injections recommended.

Lumbar myelogram/CT was done in May 1998 and showed a large right L5-S1 defect which CT scan confirmed is likely an extruded disc fragment behind the L5 vertebral body. In June 1998 following a second opinion, the patient decided to proceed with a surgery with fusion.

The patient underwent surgery on July 8, 1998 with procedures of decompressive L5-S1 laminectomy, bilateral L5 and S1 root decompression with opening of lateral recesses and foraminotomies, bilateral L5-S1 disc excision, bilateral L5-S1 interbody fusion and Bak cage implants and autograft.

On July 30, 1998 the patient was doing well post-op with no radiating leg pain. He has mild low back pain. X-rays showed good position of the cages and is walking wearing his chairback brace. He continued to improve and on October 15, 1998 he was encouraged to increase his activities and was set-up for physical therapy.

In January 1998 he is not doing so well and walks with a slightly flexed posture and has some right hip and leg pain. He has had a number of forms of conservative care. Additional imaging of CT/myelogram will be done. Lumbar myelogram done February 2, 1999 was completely normal. On February 15, 1999 epidural injections are recommended. Some benefit was obtained from an epidural injection and on March 25, 1999 he was recommended exercise therapy and work hardening.

The patient was improved some with extensive physical therapy. He could walk better and flexibility was improved. His hip and leg pain was resolved on June 14, 1999 and He had just been deemed at MMI with 16% impairment rating. In August 1999 he continued with mild low back pain and was using Ultram. He is not sure if he can return to work yet. At November 1999 reevaluation Celebrex was added. He has mild aching and tries to do yardwork. Serial radiographs show no indications of abnormal motion.

On January 27, 2000 the patient has mild aching in the low back. X-rays show considerable hypertrophic degenerative changes. The cages are in good position. He is using Ultram, Motrin and was given Ambien. He is seen bimonthly. In March 2000 he does not feel he can work. An FCE will be done.

FCE of April 2000 showed he can do light physical demand level work, however he has no education for anything but heavy labor. In June 2000 he is looking for lighter forms of work. He has no radiating hip or leg pain. In October 2000 he has good flexibility and walks normally with full lower extremity strength. He is seen quarterly.

On February 8, 2001 he is working. On June 7, 2001 he is working 12 hours per week. He uses an occasional Motrin and Ultram. Repeat FCE of July 2001 showed he can lift only 30 pounds and work an 8-hour day.

Repeat FCE of November 6, 2001 notes the patient is not working. He has a history of hypertension. He complains of lower back pain with some radiculopathy down the right leg. He can now work at a level somewhere between light and medium demand level. The examiner determined he could work an 8-hour workday between a medium and medium-heavy physical demand level.

On January 25, 2002 the patient is doing well with minimal residual low back pain and no radiating or hip pain. He has fairly good range of motion and good strength. He will be seen every six months. In July 2002 he uses Motrin and Ultram for his chronic mechanical back pain. He has no radicular leg pain.

On September 30, 2003 an epidural injection was requested for pain relief. An epidural injection was provided in October 2003 with less pain noted on October 16, 2003.

The patient did well in 2004 until December when another LESI was recommended for increased pain. LESI was approved and provided in December 2004. The patient's leg pain resolved with the LESI. Repeat epidural injections were provided on July 13, 2005 and February 10, 2006 for low back and right leg pain.

On September 21, 2006 the patient is not doing well with severe low back and radiating pain to the right leg. Updated CT/myelogram was requested but not approved. MRI of November 2006 showed bilateral foraminal narrowing at L5-S1 and annular bulging at L4-5 with foraminal narrowing. Lumbar CT/melogram was again requested in December 2006 and finally done on February 21, 2007 and showed no intradural or extradural defects and no nerve root amputations.

Epidural steroid injections were provided on 03/06/07, 01/04/08, 10/14/08 and 10/23/09 for persisting low back and right leg pain.

Request for LESI was denied on August 10, 2009 and was not supported due lack of documentation of pain in a dermatomal distribution with corroborative imaging and/or nerve study findings. It was noted that the patient's complaints change periodically. At times he has left leg pain and at other times right leg pain and at other times no leg pain. The examinations sometimes do not include motor strength testing.

On January 14, 2010 the provider noted the patient is still getting relief from an epidural injection of three months prior (10/23/09). He is using hydrocodone 5 mg and Motrin. He will return in 3 months. On April 1, 2010 he is still benefiting from the October 2009 LESI. He has some bilateral hip and leg pain, otherwise he is unchanged. He will return in 2 months. On July 9, 2010 and November 1, 2010 he is about the same.

Treatment note dated February 10, 2011 states the patient has had increasingly severe right leg radicular pain from the sciatic area down the lateral aspect of the right leg and into the foot. He has right antalgia and straight leg raise is positive at about 45 degrees. It has been about 1.5 years since his last LESI. The LESI was quite helpful providing excellent relief and reducing his need for medications and allowing for better function. LESI will be requested. He is still using hydrocodone 5 mg and Motrin.

Request for transforaminal lumbar epidural steroid injection, single level was considered in review on February 21, 2011 with recommendation for non-certification. A peer discussion was attempted but not realized. Per the reviewer, the patient has had sporadic LESIs, the last in October 2009 on the left side. The medical report of 2/10/11 indicates back and right leg pain with a positive right SLR. There is a request for a transforaminal ESI, no level or side is noted. ESI was denied in August 2009 as his symptoms kept changing. Rationale for denial notes no side or level is stated and the symptoms and findings are continuously changing. The latest not indicates a right sided pathology, yet the last LESI was to the left. The most recent examination findings do not document a neurological, sensory or motor deficit. CT showed post-op changes but does not mention scar tissue displacing nerve roots or HNP or nerve root impingement.

Request for reconsideration transforaminal lumbar epidural steroid injection, single level was considered in review on March 14, 2011 with recommendation for non-certification. A peer discussion was attempted but not realized. The notes of March 7, 2011 revealed exam findings of an antalgic gait, absent right ankle reflex, positive straight leg raise at less than 45 degrees on the right, weakness of the right foot and great toe plantar flexion. The last LESI was provided in October 2009. Rationale for denial notes, the most recent clinical records do not show any neurological, sensory or motor deficits. The documentation submitted for review is insufficient to indicate whether the patient is currently undergoing a conservative treatment program to include physical therapy for which this procedure would help facilitate. Also, there is insufficient documentation submitted for review to indicate any neurological or sensory/motor deficits. There is no documentation clarifying the duration or effect in a quantitative manner of the response to prior injection.

Request was made for an IRO.

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

ODG: LESI are 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. Chronic duration of

symptoms (greater than 6 months) has been found to decrease success rates with a threefold decrease found in patients with symptom duration greater than 24 months. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDS and muscle relaxants).

The patient has a fusion at L5-S1 with use of cages. He developed radicular symptoms in 2003 and has been provided periodic LESI since 2003. CT scan of February 2007 showed no intradural or extradural defects and no nerve root amputations. Additional LESI were provided on 03/06/07, 01/04/08. In August 2009 LESI were denied due lack of documentation of pain in a dermatomal distribution with corroborative imaging and/or nerve study findings. Additional LESI were provided on 10/14/08 and 10/23/09. The LESI of 10/23/09 provided more than 6 months of relief. However, additional LESI have not been approved due lack of documentation of a motor, sensation or reflex in a dermatome pattern with a corroborating neurocompressive lesion per imaging. It has also been noted that the patient's symptoms vary from right to left and from axial to radicular.

The current two medical reports are November 1, 2010 and February 10, 2011. On November 1, 2010 the patient still has some residual benefit from a LESI of October 2009. Medication are unchanged: Hydrocodone 5 mg. and Motrin. A thorough physical examination is not reported. On February 10, 2011 the patient has increasingly severe right leg radicular pain from the sciatic area down the lateral aspect of the right leg and into the foot of unstated duration. He has right antalgia and straight leg raise is positive at about 45 degrees. It has been about 1.5 years since his last LESI. The LESI were quite helpful providing excellent relief and reducing his need for medications and allowing for better function. He is still using hydrocodone 5 mg and Motrin. A thorough physical examination is not reported.

The patient has reportedly benefited from prior LESI and the injection of October 2009 does appear to have provided good lasting relief and better function. Medication reduction is not clarified. More recently, a thorough physical examination is not reported to clarify a motor, sensation or reflex deficit in a dermatomal distribution. Additionally, there is no corroborative imaging and/or nerve study to support a radiculopathy. CT scan of February 21, 2007 showed no intradural or extradural defects and no nerve root amputations. Criteria for LESI include participation in active rehab efforts, which also has not been clarified. Given all these factors, the documentation does not support a LESI at this time.

Therefore, my recommendation is to agree with the previous non-certification for a transforaminal lumbar epidural steroid injection, single level.

The IRO's decision is consistent with the following guidelines:

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

X ___ 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

The Official Disability Guidelines 03-14-2011: Epidural Steroid Injections:

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. Radiculopathy must be documented. Objective findings on examination need to be present.

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. 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 anesthetics, and/or opioids as a treatment for acute low back pain without radiculopathy

Use for chronic pain: Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. The ideal time of either when to initiate treatment or when treatment is no longer thought to be effective has not been determined. Indications for repeating ESIs in patients with chronic pain at a level previously injected (> 24 months) include a symptom-free interval or indication of a new clinical presentation at the level. Transforaminal approach: Some groups suggest that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations

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. 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.
- (4) Diagnostic Phase: At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
- (5) No more than two nerve root levels should be injected using transforaminal blocks.
- (6) No more than one interlaminar level should be injected at one session.
- (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 general 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.
- (11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)