IRO NOTICE OF DECISION – WC

Claims Eval

Notice of Independent Review Decision

IRO REVIEWER REPORT - WC

[Date notice sent to all parties]: June 27, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Selective Nerve Root Blocks/Left Transforaminal ESI L4-L5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
American Boards of Physical Medicine and Rehabilitation and Pain Management

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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- 8-3-11 MRI of the lumbar spine.
- 11-13-11 MD., office visit.
- 12-9-11 Transforaminal left L4-L5 epidural steroid injection.
- 2-13-12 Surgery performed by Dr..
- 2-28-12, MD., office visit.
- 3-9-12, MD., call.
- 4-20-12 MRI of the lumbar spine.
- 5-8-12 MD., office visit.

- 5-16-12 Utilization Review.
- 5-22-12, MD., office visit.
- 5-29-12 Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:
8-3-11 MRI of the lumbar spine shows narrowed L4-L5 disc. There is a moderate sized 4.5 mm posterior bulge of the disc lateralized toward the left side. This produces extrinsic pressure on the thecal sac. There is no neuroforaminal encroachment.
11-13-11 MD., the claimant complains of low back and left lower extremity pain. This patient has suffered for greater than 2 weeks from radicular symptoms without a specifically identifiable spinal nerve level etiology. There are documented findings on examination supporting a radicular pathology. MRI findings are consistent with multilevel pathology, either central, lateral recess or foraminal stenosis, likely to cause radicular pathology, however exact source for pain is ambiguous. Physical therapy / NSAID's / muscle relaxants have failed to control symptoms. There are no positive Waddell's signs or evidence of psychosocial pathology that would preclude performance of the recommended transforaminal injection procedure. Fluoroscopic guidance is indicated to assure proper injection placement and to optimize diagnostic outcome.
12-9-11 Transforaminal left L4-L5 epidural steroid injection.
2-13-12 Surgery performed by Dr.: Laminotomy with partial facetectomy, foraminotomy and neural decompression left L4-L5.
2-28-12, MD., the claimant was seen for his initial postop visit. The claimant has ongoing complaints. He recommended Medrol Dosepak and to have claimant taper up on his Neurontin. If symptoms do not improve, an MRI would be prudent.
3-9-12, MD., the claimant called with complaints of worsening left lower extremity pain. He will submit for repeat MRI.
4-20-12 MRI of the lumbar spine shows at L1-2, there is no disc bulge or herniation. No central canal or foraminal stenosis. At L2-3, no disc bulge or herniation. No central canal or foraminal stenosis. At L3-L4, no disc bulge or herniation. No central canal or foraminal stenosis. At L4-5, the patient is status post left hemilaminectomy and partial left facetectomy. There appears to be a small hematoma and associated inflammation present within the left ligamentum flavum. At L5-S1, no disc bulge or herniation. No central canal or foraminal stenosis.
5-8-12 MD., The patient complains of bilateral lower lumbar pain. The claimant underwent transforaminal epidural steroid injection on 12-9-11. Anesthetic blockade produced complete relief of the patient's usual pain. The patient had a negative steroid response with no improvement in symptoms to date. At this time, the patient has noted no relief of symptoms. The patient's VAS is 5/10 at this time. Currently, the patient has 0% relief. Exam Sensory: Pinprick sensation decreased (hypalgesia) in the following dermatomes: left - L4 and L5.
Exam Motor: Heel walking showed a drop foot with mild weakness on the left. Toe walking showed a drop heel with mild weakness on the left. Exam Reflexes: Deep tendon reflexes in the lower extremities are 2+/5 at patellar and Achilles. The evaluator recommended a transforaminal epidural steroid injection at left L4-L5.

Patient has a strongly positive left SLR for leg pain, decreased (hypalgesia) sensation Left L4, L5 distribution, along with pain on flexion.
5-16-12 UR - The patient has low back pain, also left lower extremity pain to the left leg. There is no mention of decreased sensation on the left in L4-L5. There is an imaging study that does not clearly define neuro compression at the left at these levels, also a more recent study of 4/20/12 (MRI) that shows no neuro compression at L4-5. There is no clear neuro compression that correlates with symptoms or signs. The prior SNRS on 12/9/12 led to decreased pain in the anesthetic phase, but no change in symptoms, signs, medication, etc, for the steroid phase (the reason for the surgery). This would not be consistent with ODG 2012.
5-22-12, MD., claimant complains of low back and left lower extremity pain. DOI: 7/25/2011. The pain began after a single episode of lifting at work. Symptom pattern shows back greater than leg pain. Exam Sensory: Pinprick sensation decreased (hypalgesia) in the following dermatomes: left - L4 and L5. Exam Motor: Heel walking showed a drop foot with mild weakness on the left. Toe walking showed a drop heel with mild weakness on the left. Exam Reflexes: Deep tendon reflexes in the lower extremities are 2+/5 at patellar and Achilles. Exam Special Neuro: Straight leg raise testing while seated was positive on the left for radiating leg pain. Exam Lumbar Spine: Usual pain is aggravated with flexion. Impression: postop lumbar spine s/p laminectomy L4-L5, radiculopathy secondary to lumbar disc displacement left L4 and left L5. Recommendations: Nerve root block/transforaminal epidural steroid injection left L4 and L5.
5-29-12 UR - the claimant is a male who was injured on xx/xx/xx and subsequently had a laminectomy at L4-L5 on 2-28-12. Although the clinical scenario supports the diagnostic of lumbar radiculopathy, the MRI of the lumbar spine dated 4-20-12 showed a small hematoma more than two months postop. It would be prudent to investigate this first to rule out probable causes that may affect the outcome of the requested procedure. It should be mentioned that the previous surgery of the patient on the same level of the proposed injection is considered a negative factor for its success rate. The evaluator felt the necessity of the request is not substantiated at this time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Medical records reflect a claimant status post left L4-L5 laminectomy with reported ongoing low back pain and left leg pain. The claimant had a transforaminal epidural steroid injection at left L4-L5 level without relief in symptoms. Additionally, the most recent MRI showed a small hematoma and associated inflammation present within the left ligamentum flavum.

Based on the records provided, this claimant does not meet ODG criteria for the requested Lumbar Selective Nerve Root Blocks/Left Transforaminal ESI L4-L5. There is no documentation of pain relief of at least 50-70% pain relief for at least 6-8 weeks post the first epidural steroid injection to support this request. Additionally, other causes for his pain have not been excluded, particularly with the MRI showing a hematoma at this level. Therefore, the requested Lumbar

Selective Nerve Root Blocks/Left Transforaminal ESI L4-L5 is not considered medically necessary.

ODG 2012 Lumbar epidural steroid injection: 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 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) A recent RCT of 29 patients divided into three groups addressed the use of ESIs for treatment of spinal stenosis. A control group with no treatment was compared to a group receiving passive physical therapy for two weeks and another receiving an interlaminar ESI at the stenotic level. At two weeks the group that received the ESI had significantly better pain relief than the other two groups. When the three groups were compared there was no statistical difference except in pain intensity and Roland Morris Disability Index and this was at two weeks only. The authors stated that improvement only appeared to be in the early phase of treatment. (Koc, 2009)
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. (Hopwood, 1993) (Cyteval, 2006) 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. (Riew, 2000) (Vad, 2002) (Young, 2007) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations. (Colorado, 2001) (ICSI, 2004) (McLain, 2005) (Wilson-MacDonald, 2005) Two recent RCTs of caudal injections

had different conclusions. This study concluded that caudal injections demonstrated 50% pain relief in 70% of the patients, but required an average of 3-4 procedures per year. (Manchikanti, 2011) This higher quality study concluded that caudal injections are not recommended for chronic lumbar radiculopathy. (Iversen, 2011)

Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. (Manchikanti, 1999) (Colorado, 2001) (ICSI, 2004) (Molloy, 2005) (Young, 2007)

Factors that decrease success: Decreased success rates have been found in patients who are unemployed due to pain, who smoke, have had previous back surgery, have pain that is not decreased by medication, and/or evidence of substance abuse, disability or litigation. (Jamison, 1991) (Abram, 1999) Research reporting effectiveness of ESIs in the past has been contradictory, but these discrepancies are felt to have been, in part, secondary to numerous methodological flaws in the early studies, including the lack of imaging and contrast administration. Success rates also may depend on the technical skill of the interventionalist. (Carette, 1997) (Bigos, 1999) (Rozenberg, 1999) (Botwin, 2002) (Manchikanti , 2003) (CMS, 2004) (Delport, 2004) (Khot, 2004) (Buttermann, 2004) (Buttermann2, 2004) (Samanta, 2004) (Cigna, 2004) (Benzon, 2005) (Dashfield, 2005) (Arden, 2005) (Price, 2005) (Resnick, 2005) (Abdi, 2007) (Boswell, 2007) (Buenaventura, 2009) Also see Epidural steroid injections, "series of three" and Epidural steroid injections, diagnostic. ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. (Kinkade, 2007) Epidural steroid injections are an option for short-term pain relief of persistent radiculopathy, although not for nonspecific low back pain or spinal stenosis. (Chou, 2008) As noted above, injections are recommended if they can facilitate a return to functionality (via activity & exercise). If post-injection physical therapy visits are required for instruction in these active self-performed exercise programs, these visits should be included within the overall recommendations under Physical therapy, or at least not require more than 2 additional visits to reinforce the home exercise program.

With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008)

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. (Deyo, 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) ESIs are more often

successful in patients without significant compression of the nerve root and, therefore, in whom an inflammatory basis for radicular pain is most likely. In such patients, a success rate of 75% renders ESI an attractive temporary alternative to surgery, but in patients with significant compression of the nerve root, the likelihood of benefiting from ESI is low (26%). This success rate may be no more than that of a placebo effect, and surgery may be a more appropriate consideration. (Ghahreman, 2011) According to this RCT, the use of MRI before ESIs does not improve patient outcomes and has a minimal effect on decision making, but the use of MRI might have reduced the total number of injections required and may have improved outcomes in a subset of patients. Given these potential benefits as well as concerns related to missing important rare contraindications to epidural steroid injection, plus the small benefits of ESIs themselves, ODG continues to recommend that radiculopathy be corroborated by imaging studies and/or electrodiagnostic testing. (Cohen, 2012)

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.)

IRO REVIEWER REPORT TEMPLATE -WC

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)**