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Notice of Independent Review Decision

Date notice sent to all parties:

August 27, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

possible appeal lumbar caudal ESI #1 with the C-arm / not medically certified by peer advisor

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

Board Certified Anesthesiologist; Board Certified Pain Medicine

REVIEW OUTCOME:

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

X Upheld (Agree)

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Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is described as lifting. Initial treatment includes epidural steroid injection on 05/24/02 and posterior lumbar interbody fusion in December 2002. IME dated 05/06/03 indicates that diagnoses are status post L4-5 fusion and left lower extremity radiculopathy. The patient subsequently underwent revision of left L4-5 pedicle screw instrumentation, posterior lateral fusion and exploration of anterior fusion on 05/28/03. The patient underwent thoracic epidural steroid injection on 07/11/03. Note dated 09/23/05 indicates that the patient underwent spinal cord stimulator implantation and is feeling quite good in regards to her back and leg pain. The

patient underwent lumbar epidural steroid injection on 01/31/13 with 90-100% improvement for 2 weeks. The patient underwent lumbar caudal epidural steroid injection on 05/14/13. Lumbar CT scan dated 08/08/13 revealed status post fusion at L3-4 and L4-5, foraminal disc osteophyte changes at L5-S1 result in bilateral neural foraminal stenosis with contacting of the exiting L5 nerve roots left greater than right, moderate central canal stenosis at L2-3 secondary to facet hypertrophy, ligamentum flavum thickening and minimal disc bulging. The patient underwent caudal epidural steroid injection on 10/08/13 and reported 70% improvement on 10/17/13. The patient underwent caudal epidural steroid injection on 12/19/13 and reported equivocal relief. EMG/NCV dated 04/21/14 revealed evidence of right L5-S1 lumbosacral radiculopathy which is both acute and chronic in nature. There is no evidence of left lower extremity radiculopathy. Note dated 05/08/14 indicates

that the spinal cord stimulator is working well. Follow up note dated 07/07/14 indicates that gait and stance are normal. Assessment is low back pain.
Initial request for lumbar caudal epidural steroid injection with C-arm was non-certified on 06/26/14 noting that the request in question represents a repeat injection. The claimant has had at least one earlier injection during the life of the claim. There is no clear evidence of functional improvement and/or lasting pain relief achieved with earlier blocks. There is no clear evidence of functional improvement as defined by the measures established in ODG. The denial was upheld on appeal dated 07/22/14 noting that there is no documented improvement noted from the prior caudal epidural steroid injections. She has completed three epidurals within the last twelve months. There is no clinical evidence of radiculopathy on a consistent basis.

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

Based on the clinical information provided, the request for lumbar caudal epidural steroid injection #1 with C-arm is not recommended as medically necessary. The patient's most recent caudal epidural steroid injection was performed on 12/19/13, and the patient reported equivocal relief. The Official Disability Guidelines require documentation of at least 50% pain relief for at least 6-8 weeks prior to the performance of a repeat epidural steroid injection. The submitted records fail to establish that the patient's post-injection pain relief meets this criterion. The most recent office visit note submitted for review fails to provide a detailed physical examination to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines. Given the current clinical data, the requested epidural steroid injection is not indicated as medically necessary.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Neck and Upper Back Chapter
Epidural steroid injection (ESI)
Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. In a recent Cochrane review, there was one study that reported improvement in pain and function at four weeks and also one year in individuals with chronic neck pain with radiation. (Peloso-Cochrane, 2006) (Peloso, 2005) Other reviews have reported moderate short-term and long-term evidence of success in managing cervical radiculopathy with interlaminar ESIs. (Stav, 1993) (Castagnera, 1994) Some have also reported moderate evidence of management of cervical nerve root pain using a transforaminal approach. (Bush, 1996) (Cyteval, 2004) A recent retrospective review of interlaminar cervical ESIs found that approximately two-thirds of patients with symptomatic cervical radiculopathy from disc herniation were able to avoid surgery for up to 1 year with treatment. Success rate was improved with earlier injection (< 100 days from diagnosis). (Lin, 2006) There have been recent case reports of cerebellar infarct and brainstem herniation as well as spinal cord infarction after cervical transforaminal injection. (Beckman, 2006) (Ludwig, 2005) Quadriparesis with a cervical ESI at C6-7 has also been noted (Bose, 2005) and the American Society of Anesthesiologists Closed Claims Project database revealed 9 deaths or cases of brain injury after cervical ESI (1970-1999). (Fitzgibbon, 2004) These reports were in contrast to a retrospective review of 1,036 injections that showed that there were no catastrophic complications with the procedure. (Ma, 2005) The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral 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, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) There is evidence for short-term symptomatic improvement of radicular symptoms with epidural or selective root injections with corticosteroids, but these treatments did not appear to decrease the rate of open surgery. (Haldeman, 2008) (Benyamin, 2009) Epidural steroid injections should be reserved for those who may otherwise undergo open surgery for nerve root compromise. (Bigos, 1999) Intramuscular injection of lidocaine for chronic mechanical neck disorders (MND) and intravenous injection of methylprednisolone for acute whiplash were effective treatments. There was limited evidence of effectiveness of epidural injection of methyl prednisolone and lidocaine for chronic MND with radicular findings. (Peloso-Cochrane, 2006) The FDA is warning that injection of corticosteroids into the epidural space of the spine may result in rare but serious adverse events, including loss of vision, stroke, paralysis, and death. (FDA, 2014) See the Low Back Chapter for more information and references.

Criteria for the use of Epidural steroid injections, therapeutic:

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

(1) Radiculopathy must be documented by physical examination and 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) for guidance
(4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.

(8) Repeat injections should be based on continued objective documented pain and function response.

(9) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or 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.

Criteria for the use of Epidural steroid injections, diagnostic:

To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:

(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;

(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;

(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution), and imaging studies have suggestive cause for symptoms but are inconclusive;

(4) To help to identify the origin of pain in patients who have had previous spinal surgery.