

The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205
Phone: 888-950-4333 Fax: 888-9504-4443

Notice of Independent Review Decision

August 19, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Medical Necessity: Lumbar Epidural Steroid Injection (ESI) Right L4-5

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. The physician is certified in pain management. The physician has a private practice of Physical Medicine & Rehabilitation, Electro Diagnostic Medicine & Pain Management in Texas. The physician is a member of the Texas Medical Association and the Houston Physical Medicine and Rehabilitation Society. The physician is licensed in Texas and Michigan and has been in practice for over 25 years.

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.

Upon independent review the physician finds that the previous adverse determination should be ~ Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a man who was injured in a fall down stairs in xxxx. He developed back pain. He apparently had an epidural injection and other treatments in the past including hardware injections. The fusion apparently was in 2013. A prior request for a right (meant to say left) ESI was denied for the technical issues of the wrong side. Some notes describe a caudal approach was being considered due to the

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prior fusion on the right side. The exam was reported as showing a positive left SLR, left 4/5 dermatomal sensory deficits and subjective weakness without objective weakness or atrophy in the left lower extremity. Apparently he had a CT scan in August 2014 that showed a solid fusion. One reviewer felt the absence of electrodiagnostic studies precluded the ESI. This was considered necessary for the documentation of the radiculopathy. The records from TASB show that the request for the EMG/NCS was denied on 3/13/15. The CT scan from 8/24/14 is hard to read, but discusses the fusion. There was no comment of specific nerve root compromise, as this can not be seen on CT scans. The studies showed nueral foraminal narrowing from L3/4 to L5/S1.

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

The indications for an ESI is the presence of a radiculopathy. Earlier editions of the ODG cited the findings in the AMA Guides 5th edition for the presence of a radiculopathy. When I pointed out the 4th edition was used in Texas, this definition was revised.

From the ODG.

Epidural steroid injections (ESIs), therapeutic	<p>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. Not recommended for spinal stenosis or for nonspecific low back pain. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, but ESIs have not been found to be as beneficial a treatment for the latter condition. According to SPORT, ESIs are associated with less improvement in spinal stenosis. (Radcliff, 2013)...</p> <p><i>Transforaminal approach:</i> 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) Transforaminal epidural steroid injections, despite being generally regarded as superior to interlaminar injections, are not significantly better in providing pain relief or functional improvement, according to a new systematic review. (Chien, 2014)... 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)...</p>
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Patient selection: Radiculopathy must be documented, as indicated in the ODG criteria. In addition, 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](#))

Injections for spinal pain have high failure rates, emphasizing the importance of patient selection.

Individuals with centralized pain, such as those with fibromyalgia and chronic widespread pain, and poorly controlled depression, may be poor candidates.

([Brummett, 2013](#))

MRIs: 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 (due to herniated nucleus pulposus, but not spinal stenosis) 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, muscle relaxants & neuropathic drugs).

(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

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	<p>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.</p> <p>(5) No more than two nerve root levels should be injected using transforaminal blocks.</p> <p>(6) No more than one interlaminar level should be injected at one session.</p> <p>(7) <i>Therapeutic phase:</i> 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)</p> <p>(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.</p> <p>(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.</p> <p>(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.</p> <p>(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.)</p>
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So in essence, he needs to have a radiculopathy present based on clinical and radiological findings and/or electrodiagnostic testing. Both are not needed. There was a prior request for the electrodiagnostic studies and these were denied. So the logic previously presented was he can not have the ESI because he did not have EDX, and he was not allowed to have the EDX (electrodiagnostic studies). That is an absurd point.

Further, the ODG does not define a radiculopathy. The older editions relied on the following from the 5th edition of the AMA Guides to the Evaluation of Permanent Impairment.

“...For reflex abnormalities to be considered valid, the involved and normal limb(s) should show marked asymmetry...”

“Weakness and Loss of Sensation

“To be valid, the sensory findings must be in a strict anatomic distribution, i.e follow dermatomal patterns...Motor findings should be consistent with the affected nerve structures(s). Significant, long standing weakness is usually accompanied by atrophy.”

“Radiculopathy

Radiculopathy for the purposes of the Guides is defined as significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness, and/or

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paresthesias in a dermatomal distribution. The diagnosis of herniated disc must be substantiated by an appropriate finding on the imaging study. The presence of findings on a imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be evidence as described above. “

“Atrophy

Atrophy is measured with a tape measure at identical levels on both limbs. For reasons or reproducibility, the difference in circumference should be 2cm or greater in the thigh and 1cm or greater in the arm, forearm, or leg...”

“Electrodiagnostic verification of Radiculopathy.

Unequivocal electrodiagnostic evidence of acute nerve root pathology includes the presence of multiple positive sharp waves or fibrillation potentials in muscles innervated by one nerve root. However the quality of the person performing and interpreting the study is critical. Electromyography should be performed only by a licensed physician qualified by reason of education, training and experience in these procedures.

Electromyography does not detect all compressive radiculopathies and cannot determine the cause of the nerve root pathology. On the other hand, electromyography can detect noncompressive radiculopathies, which are not identified by imaging studies. “

Page 382-382. AMA Guides to the Evaluation of Permanent Impairment. 5th edition

So, in short, he has many, but not all of the above criteria for a radiculopathy. The missing criteria are MRIs that could not be done, but has a hint of the problem on a CT scan from 2014. The option is the EMG to confirm the radiculopathy, but that was denied as well. It would appear then the single ESI would be justified as there is enough evidence to suggest a radiculopathy, and the missing criteria was precluded by the insurance company.

Therefore, I find the ESI is an appropriate treatment at this time.

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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)