

INDEPENDENT REVIEWERS OF TEXAS, INC.

2150 S. Central Expressway · Suite 200-264 · McKinney, Texas 75070

Office 214-533-2864 Fax 469-219-3349

e-mail: independentreviewers@hotmail.com

Notice of Independent Review Decision

[Date notice sent to all parties]:

04/23/2018

IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

lumbar epidural blockade at L5-S1 under fluoroscopy with IV sedation

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

DO, Board Certified Anesthesiology

REVIEW OUTCOME:

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

X Upheld

(Agree)

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 XX whose date of injury is XXXX. The patient was XX felt immediate onset of low back pain. Treatment to date is noted to include physical therapy, injections, medication management, home exercise program and work conditioning program. The patient underwent lumbar epidural steroid injection at L5-S1 on XXXX, XXXX and XXXX. Follow up note dated XXXX indicates that the patient continues to work albeit with moderate to severe axial back pain formally effectively treated with lumbar epidural blockade. The patient did well in the past with more than 70% pain relief, improved function and decreased medications. XX feels XX back pain has recurred. XX has positive straight leg raising on the right at 60 degrees. XX has decreased pinprick in the L5-S1 distribution. Current medications are XX, XX, XX. The initial request for lumbar epidural blockade at L5-S1 under fluoroscopy with IV sedation was non-certified noting that the guidelines require objective evidence of radiculopathy on physical examination and corroboration on imaging. There were no imaging studies submitted for review. No electrodiagnostic studies were submitted reporting radiculopathy. The physical examination did not show decreased sensation in a dermatomal distribution, decreased strength in a myotomal distribution, or loss of relevant reflex. Records do not reflect after previous epidural steroid injections of 50-70 percent pain relief

for XX. The denial was upheld on appeal noting that per evidence based guidelines, repeat injections should be based on continued objective documented pain relief, decreased the need for pain medications, and functional response. This XX reportedly did well in the past with more than 70 percent pain relief, improved function, and decreased medications after XX previous epidural steroid injection. Medical records submitted are not documented in a format that delineates physical examination findings, so it is difficult to tell what objective findings were documented in XX medical records. However, there was limited documentation of objective functional improvement from prior injections to warrant the need for an additional injection. The simple statement that XX had “70 percent pain relief, improved function and decreased medications” is insufficient to validate efficacy. There should be documentation of actual medications used and by how much they were decreased, as well as specific functional improvements or functional goals for continued rehab. Additionally, there was also no clear documentation that the patient had exhausted and failed conservative treatments. There was also no documentation if this injection will be used in conjunction with active rehab efforts.

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 epidural blockade at L5-S1 under fluoroscopy with IV sedation is not recommended as medically necessary, and the two previous denials are upheld. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. There are no recent imaging studies/electrodiagnostic results submitted for review as the MRI of the lumbar spine provided is over XX. There remains no information regarding pre- and post-epidural steroid injection medication regimens. There are no objective measures of improvement documented following prior epidural steroid injections. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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

**X 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
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

**Official Disability Guidelines Treatment Index, 23rd edition online, 2018-Low
Back Chapter updated 12/28/17**

Epidural steroid injections (ESIs), therapeutic

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.

See the Neck Chapter, where ESIs are not recommended based on recent evidence, given the serious risks of this procedure in the cervical region and the lack of quality evidence for sustained benefit.

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, the reduction of medication use and the avoidance of 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, and 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 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.)

(12) Excessive sedation should be avoided.

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)

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)

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.

For spinal stenosis: The use of epidural steroid injection (ESI) in patients with lumbar spinal stenosis is common, but there is little evidence in the literature to demonstrate its long-term benefit. Despite equivalent baseline status, ESIs are associated with significantly less improvement at 4 years among all patients with spinal stenosis. Furthermore, ESIs were associated with longer duration of surgery and longer hospital stay. There was no improvement in outcome with ESI whether patients were treated surgically or nonsurgically. There was no distinct surgical avoidance noted with ESI. (Radcliff, 2013) This systematic review found the data was limited to suggest that ESI is effective in lumbar spinal stenosis. (Bresnahan, 2013) An RCT addressed the use of ESIs for treatment of spinal stenosis, and there was no statistical difference except in pain intensity and Roland Morris Disability Index and this was at two weeks only. (Koc, 2009) According to the APS/ ACP guidelines, ESIs are not for nonspecific low back pain or spinal stenosis. (Chou, 2008) According to a high-quality RCT, in the treatment of symptoms of lumbar spinal stenosis, epidural injections of glucocorticoids plus lidocaine offered minimal or no benefit over epidural injections of lidocaine alone at 6 weeks. At 3 weeks, the glucocorticoid-lidocaine group had greater improvement than the lidocaine-alone group, but the differences were clinically insignificant. Despite a rapid increase in the use of epidural glucocorticoid injections for lumbar spinal stenosis, there is little evidence of effectiveness from clinical trials. (Friedly, 2014)

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) 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)

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) (Delpont, 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 and 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) Not recommended post-op. The evidence for ESI for post lumbar surgery syndrome is poor. (Manchikanti, 2012)

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)

Fracture risk: Lumbar ESIs are associated with an increased risk for spinal fracture. Each single additional ESI increased the risk for fracture by 21%, with an increasing number of ESIs associated with an increasing likelihood of fracture. Use of ESIs seems to promote deterioration of skeletal quality. This definable fracture risk should be balanced with the best available evidence regarding the long-term efficacy of ESIs, which is limited. Clinicians should consider these findings before prescribing ESIs for elderly patients. (Mandel, 2013)

Sedation: The use of sedation during ESI remains controversial. Sedation is less often indicated during lumbar ESI compared with cervical ESI because fewer patients experience a vasovagal reaction, which is likely an indicator of anxiety. (Trentman, 2009) According to a multidisciplinary collaboration led by the FDA, heavy sedation should be avoided in favor of sedation light enough to allow the patient to communicate during the procedure. (Rathmell, 2015) For a more extensive discussion, see the Pain Chapter. See also the Neck Chapter.

Recent research: 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) In this RCT there were no statistically significant differences between any of the three groups at any time points. This study had some limitations: only one type of steroid in one dose was tested; the approach used was caudal and transforaminal injections might provide superior results. (Weiner, 2012) Effects are short-term and minimal. At follow-up of up to 3 months, epidural steroids were associated with statistically significant reductions in mean leg pain and mean disability score, but neither of these short-term improvements reached the threshold for clinical significance. There were no significant differences in either leg pain or disability at the 12-month follow-up. (Pinto, 2012) According to this systematic review, ESIs without the drug (epidural nonsteroid injections), often used as a placebo treatment, were as effective as ESIs and better than no epidural injections. (Bicket, 2013) This meta-analysis suggested that ESI did not improve back-specific disability more than a placebo or other procedure long-term (6 months), and did not significantly decrease the number of patients who underwent subsequent surgery. (Choi, 2013) 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) This study shows that ESIs had a significant beneficial effect as an additional treatment for lumbosacral radicular syndrome in general practice, but the effect was too small to be considered clinically relevant to patients, so the authors do not recommend ESIs as a regular intervention in general practice. (Spijker-Huiges, 2014) A high-quality RCT concluded that gabapentin and ESIs for radicular pain both resulted in modest improvements in pain and function, which persisted through three months. Some differences favored ESIs, but these tended to be small and transient. They recommended a trial with neuropathic drugs as a reasonable first line treatment option. (Cohen, 2015) The AHRQ comparative effectiveness study on injection therapies for LBP concluded that ESIs for radiculopathy were associated with immediate improvements in pain and might be associated with immediate improvements in function, but benefits were small and not sustained, and there was no effect on long-term risk of surgery. Evidence did not suggest that effectiveness varies based on injection technique, corticosteroid, dose, or comparator. Limited evidence suggested that epidural corticosteroid injections are not effective for spinal stenosis or nonradicular back pain. (Chou, 2015) In another systematic review, evidence was only robust for positive effects in patients with chronic radiculopathy, with statistically significant effects on immediate (5 days to ≤ 2 weeks) improvement in pain, and short-term (> 2 weeks to ≤ 3 months) surgery risk. (Chou, 2015b)