

**CORE 400 LLC**  
240 Commercial Street, Suite D  
Nevada City, California 95959

Notice of Independent Review Decision

**DATE OF REVIEW: DECEMBER 22, 2008**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar Epidural Steroid Injection L5-S1 using Fluoroscopy.

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

MD, Board Certified Orthopedic Surgeon

**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 or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for Lumbar Epidural Steroid Injection L5-S1 using Fluoroscopy.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 10/02/08 and 10/30/08  
ODG Guidelines and Treatment Guidelines  
Office Note, Dr.: 08/09/07  
Office Notes, Dr.: 09/14/08, 09/27/08  
Required Medical Evaluation: 02/26/08  
Impairment Rating Evaluation: 05/14/08 and 09/24/08  
Electrodiagnostic studies: 07/09/08  
Functional Capacity Evaluation: 09/24/08

Letters, Dr. : 10/20/08 and 10/30/08  
Lumbar MRI, 06/27/07  
MD articles related to sciatica

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a xx year-old female who fell on the steps landing on her buttocks on xx/xx/xx. Lumbar MRI evaluation on 06/27/07 noted L4-5 and L5-S1 disc bulging with minimal contact on the thecal sac. Dr. evaluated the claimant on 08/09/07 for complaints of severe low back pain and episodic lower extremity paresthesias. It was noted that the claimant had gained thirty pounds with a current weight of 266 pounds. Conservative treatment was outlined with inclusion of aquatic physical therapy, Naprosyn and Skelaxin. Dr. felt the 6/27/07 MRI revealed L5-S1 disc protrusion and L4-5 annular tear with disc desiccation mainly at L5-S1 and mildly at L4-5. Physical examination demonstrated intact strength, reflex and sensation findings with positive right straight leg raise. Dr. recommended weight loss and evaluation by pain management with discogram. Dr. evaluated the claimant for pain management on with examination findings of tender right sacroiliac joint; pain with extension and lateral flexion; tender L4-5 and L5-S1 facets; and normal motor, reflex and sensation findings. Dr. diagnosed discogenic pain and lumbar facet syndrome. Dr. also recommended discogram evaluation. A required medical evaluation conducted on 02/26/08 indicated the claimant was not a candidate for epidural steroid injection, discogram or surgery. The evaluator noted the claimant required no further treatment other than a short course of physical therapy to establish a home exercise program. An impairment rating evaluation on 05/14/08 referenced normal lumbar radiographs on 05/07/07; normal right hip radiographs on 06/08/07; prior release to regular duty work on 09/18/06; and reference to an exacerbation that lead to a light duty release on 05/07/07. The evaluator did not feel the claimant was at maximum medical improvement and the claimant underwent electrodiagnostic studies on 07/09/08 that were within normal limits. A repeat impairment rating evaluation completed on 09/24/08 placed the claimant at maximum medical improvement with a five percent impairment rating. A functional capacity evaluation performed on 09/24/08 indicated the claimant demonstrated the ability to lift and carry ten pounds, as well as the capacity for sedentary physical demand level. On 09/27/08 Dr. documented findings of absent left ankle reflex and recommended L5-S1 epidural steroid injection. The injection was denied due to no documentation of radiculopathy. Dr. responded with a letter on 10/20/08 that indicated the dropped left ankle reflex represented a left S1 nerve root impairment and that the claimant had a positive straight leg raise that could indicate sciatic tension and nerve entrapment. Dr. requested reconsideration and was once again denied due to the lack of documented radiculopathy. A medical dispute was filed for the continued recommendation of L5-S1 epidural steroid injection.

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

The request for lumbar epidural steroid injection L5-S1 using fluoroscopy (62311, 77003, 01992) for this xx-year-old female who was injured on xx/xx/xx cannot be recommended as medically necessary. In review of the objective findings on 06/27/07, an MRI demonstrates disc bulging at L4-5, L5-S1 with no significant neural compressive lesion. The EMG/NCS on 07/09/08 was within normal limits. It is unclear what is being treated with this epidural steroid injection based upon these medical records. Epidural steroid injection is not indicated and appropriate as per the ODG Guidelines. The reviewer finds that medical necessity does not exist for Lumbar Epidural Steroid Injection L5-S1 using Fluoroscopy.

## Official Disability Guidelines Treatment in Worker's Comp 2008 Updates; Low Back-Epidural Steroid Injection

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, 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. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#))
- (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 required. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of 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.)

### **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)**