

C-IRO, Inc.
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: JULY 14, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid Injection with Fluoroscopy and MAC Anesthesia, 62311, 01992, 77003

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

MD, Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in 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 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 with Fluoroscopy and MAC Anesthesia, 62311, 01992, 77003.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 4/25/08, 5/23/08
ODG Guidelines and Treatment Guidelines
, MD, 6/2/08, 5/12/08, 4/22/08, 5/16/08
Initial FCE, 2/25/08
CT Lumbar Spine w/Contrast, 5/2/07
MRI of Lumbar Spine, 2/5/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This woman was injured with a fall in XX/XX. She has back pain and reportedly lower extremity pain. The chart states this is in a dermatomal pattern. She had MRIs and discograms that showed annular tears at L3/4 and L4/5. The MRI reportedly showed a right paramedian disc protrusion at L4/5 not compromising a nerve root or entering the neural foramen. The lumbar discograms demonstrated concordant pain at these levels. She was felt not to be a surgical candidate. She reportedly has motor weakness (4+/5+) along the bilateral plantarflexors and absent ankle jerks. She has diabetes.

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

The reviewer finds that medical necessity does not exist for Lumbar Epidural Steroid Injection with Fluoroscopy and MAC Anesthesia, 62311, 01992, 77003.

The ODG approves epidural injections for demonstrable radiculopathy. The pain here was reportedly dermatomal, but the dermatome was not identified in the report. The patient reportedly had bilateral positive SLR with the pain going into the buttocks. There was no description of the pain into the calves or feet. She has absent ankle jerks and no demonstrated sensory loss. There is diabetes present. A unilateral reflex abnormality and motor loss consistent with a radiculopathy is not described in radiological studies. Bilateral findings reportedly exist, but are not described on the radiological studies. The MRI did not demonstrate a disc herniation on nerve roots.

The requirements rely upon the AMA criteria for radiculopathy. These include 1) "appropriate finding on an imaging study. The presence of findings on an imaging study in and of itself does not make the diagnosis of radiculopathy." 2) "Unequivocal electrodiagnostic evidence of acute nerve root pathology..." The sensory findings must be in a strict anatomical distribution...dermatomal patterns." It also cites the presence of motor weakness that is "consistent with the affected nerve structure(s)." None of this was verified in the material provided for review. Discogenic pain does not respond to epidural injections.

Lumbar Epidural Steroid Injection per the ODG is:

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. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus...

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. ...

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.

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](#)).

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and 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](#)) (see below)

(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 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)