

P-IRO Inc.

An Independent Review Organization

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DATE OF REVIEW: November 26, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of ESI, lumbar spine under fluoroscopic control with epidurogram

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Peer Review, 10/01/08, 10/27/08

Office notes, Dr., 09/11/06, 11/03/06, 01/08/07, 03/12/07, 06/18/07, 09/10/07, 10/22/07

Office note, Dr., 03/05/08

Office notes, Dr., 05/22/08, 09/24/08

X-ray lumbar spine, 06/0/608

MRI lumbar spine, 10/07/02, 06/06/08

EMG/ NCS, 11/14/02

OT evaluation, 05/14/07

Texas Worker's Compensation work status report, 03/05/08

Letter / Dr. 10/17/08, 10/31/08

Independent Review Organization of Summary, 11/02/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old female claimant who reportedly had a slip and fall in xx/xx which resulted in low back pain and associated left lower extremity symptoms. An MRI of the lumbar spine performed on xx/xx/xx showed small central disc protrusions at L5- S1 along with facet degenerative changes and mild foraminal narrowing and an annular tear at L4-5. Lumbar x-rays performed in 2006 revealed narrowing of disk space at L5- S1 with anterolisthesis at L4-5. The records indicate that the claimant treated conservatively with numerous medications, lumbar epidural steroid injections in 2006 with approximately forty percent relief, bilateral joint injections and lumbar facet injections.

In 2007, the claimant was noted to have continued lumbosacral pain and bilateral sacroiliac joint pain along with bilateral left greater than right leg radiculopathy. The claimant was diagnosed with anterolisthesis L4-5, lumbar diskogenic disease L5- S1, lumbar facet arthropathy L4-5 and L5- S1 bilaterally, lumbar myositis, bilateral sacroiliac joint lumbar dysfunction, disc bulge L4-5 and L5-S1 with bilateral leg radiculopathy. Physician records indicated that the claimant had weather change pain and morning stiffness. Epidural steroid injections would be considered if the claimant's pain pattern persisted. An acute flare up of the lumbar pain and bilateral leg pain was noted in September 2007.

A 05/22/08 physician record note the claimant with continued low back pain. X-rays showed narrowed discs L4-5 and L5-S1 with facet arthropathy and bridging osteophytes in the thoracolumbar region. An examination revealed decreased lumbar motion, weakness in the extensor hallucis longus and decreased sensation in the left lower extremity. A lumbar MRI followed on 06/06/08 which showed disc desiccation, loss of disc height and minimal anterolisthesis at L5- S1 and a annular bulge / protrusion at L4-5. A left L5- S1 epidural steroid injection was recommenced along with a L5- S1 facet injection.

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

The requested lumbar epidural steroid injection under fluoroscopy **control with epidurogram** is not medical necessity based on review of this medical record.

This claimant has a long history of chronic back pain and has undergone lumbar epidural steroid injections in 2006 with only 40% relief. They have also undergone multiple different types of conservative care to include medications, TENS unit, activity modification, and facet injections. There has been a discussion over time in the record of trying another epidural steroid injection, but there is no documentation in change in this claimant's specific physical findings or progressive neurologic deficit.

ODG guidelines document the use of epidural steroid injections in patients who have radiculopathy and after an initial block there needs to be at least 50 to 70% pain relief for 6 to 8 weeks before other blocks may be used. In this case this claimant had 3 blocks a couple of years ago that gave only 40% relief. There is also no documentation in the medical literature that epidural steroid injections give people good long term relief.

Therefore, based on review of this medical record and the fact the claimant has had epidural steroid injections in the past without good relief and the fact that there has been

no acute change in this claimant's medical condition or change on the new diagnostic testing of other new abnormality, therefore the requested epidural steroid injection is not medically necessary. This reviewer therefore agrees with the determination of the insurance carrier.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Low Back : 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 or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition.

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.

(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)