



Medical Review Institute of America, Inc.
America's External Review Network

DATE OF REVIEW: August 20, 2009

IRO Case #:

Description of the services in dispute:

This is the final level appeal of caudal epidural steroid injection denied by insurance as not medically necessary. Please review all submitted information and advise. Please review for medical necessity only.

A description of the qualifications for each physician or other health care provider who reviewed the decision:

The physician providing this review is board certified in Anesthesiology. The reviewer holds additional certification in Pain Medicine from the American Board of Pain Medicine. The reviewer is a diplomate of the National Board of Medical Examiners. The reviewer has served as a research associate in the department of physics at MIT. The reviewer has received his PhD in Physics from MIT. The reviewer is currently the chief of Anesthesiology at a local hospital and is the co-chairman of Anesthesiology at another area hospital. The reviewer has been in active practice since 1978.

Review Outcome:

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

Overtaken.

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 requested caudal epidural steroid injection is medically necessary for this patient.

Information provided to the IRO for review

Notice of case assignment 7/31/09 1 page

Confirmation of receipt of a request for a review by an IRO 5 pages

Authorization request form 1 page
MRI lumbar spine 3/5/09 2 pages
 medical centers office visit notes 6/15/09, 6/23/09, 7/2/09 11 pages
Request for reconsideration 7/13/09 1 page
Dr. office visit notes 7/24/09 2 pages
Lumbar spine MRI 7/24/09 1 page
Peer review determination letter undated 2 pages
MRI lumbar spine 6/5/09 1 page
 notification of determination 7/10/09 2 pages
 reconsideration determination 7/20/09 4 pages
Notice of disputed issue and refusal to pay benefits 6/26/09 1 page
MRI lumbar spine 6/5/09 4 pages
Peer review report 6/18/09 5 pages
Peer review addendum 6/20/09 5 pages
 Status Reports 6/25/09, 7/5/09 2 pages
Orthopedic spinal evaluation 7/2/09 2 pages
Carrier submission from the 8/5/09 7 pages
ODG-TWC Treatment Guidelines Low Back-Lumbar & Thoracic (Acute & Chronic) 319 pages

Patient clinical history [summary]:

The patient is a xx-year-old male who suffered a workplace injury on xx/xx/xx. Subsequently he developed low back pain, which radiates down the right leg. Physical examination reveals positive straight leg raising and Lasegue's signs on the right. MRI reveals an acute compression fracture of L4 and right L4-5 neuroforaminal stenosis. He has been treated with rest and Vicodin. An epidural steroid injection to treat the acute radicular pain and vertebroplasty to stabilize the compression fracture has been recommended.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision:

According to the submitted medical record, the patient appears to satisfy the criteria for an epidural steroid injection according to the ODG Treatment Index as listed below. The documentation of 1) positive straight leg raising and positive Lasegue's signs on the right with MRI evidence of right L4-5 neuroforaminal stenosis constitutes objective evidence of lumbar radiculopathy. Although he has not had physical therapy, the conservative treatment including rest and low-dose opioids is appropriate, given the new L4 compression fracture. He has not undergone previous epidural steroid injections. Based on the ODG guidelines, an initial epidural steroid injection appears to be medically indicated.

A description and the source of the screening criteria or other clinical basis used to make the decision:

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)

(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) 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 two injections should be performed. A second block is not recommended if there is inadequate response to the first block. 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. To be considered successful after this initial use of a block/blocks there should be documentation of at least 50–70% relief of pain from baseline and evidence of improved function for at least six to eight weeks after delivery.

(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) In the therapeutic phase (the phase after the initial block/blocks were given and found to produce pain relief), repeat blocks should only be offered if there is at least 50–70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)

(8) Repeat injections should be based on continued objective documented pain 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.

Objective finding supporting the diagnosis of radiculopathy:

1. A dermatomal distribution of pain, numbness and/or paresthesias,
2. Positive root tension signs,
3. A herniated disk substantiated by an 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. There must also be clinical evidence.
4. Unequivocal electrodiagnostic evidence of acute nerve root pathology includes the presence of multiple positive sharp waves or fibrillation potentials in muscles innervated by the nerve root . . . Electromyography should be performed only by a licensed physician qualified by reason of education, training and experience in these procedures.

Official Disability Guidelines, Web Edition. Encinitas, CA: Work Loss Data Institute. http://www.odg-twc.com/odgtwc/low_back.htm

Cocchiarella, L and Andersson, G.B.J., Guides to the Evaluation of Permanent Impairment, 5th edition. Chicago: AMA Press, 2001, pp. 382–383.