DATE OF REVIEW: December 8, 2009

IRO Case #:

Description of the services in dispute:

Lumbar Epidural L5 CPT codes #62311, #77003, and #72275.

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

The clinician who provided this review is a licensed chiropractor. This reviewer is a member of the American Chiropractic Association. This reviewer has been in active practice since 1985.

Review Outcome

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

Upheld.

Based on review of all submitted documentation and evidence based guidelines the reviewed L5 epidural steroid injection is not medically necessary.

Information provided to the IRO for review

Records Received fro the State:

1) Peer Review Referral form, 1 page.
2) IRO request, 4 pages.
3) Copy of ODG's, Low back, 3 pages.
4) Treatment history of previous injections, unreadable, 2 pages.
5) Correspondence dated 11/04/2009, 4 pages.
5) Correspondence dated 10/21/2009, 5 pages.
6) Request for IRO dated 11/20/2009, 2 pages.
7) Report from Dr. dated 10/29/2009, 3 pages.
8) IME report dated 10/26/2009 by Dr. 4 pages.
9) Reports dated 06/18/2009, 07/08/2009, 08/04/2009 14 pages.
10) Electro diagnostic report by Dr. dated 05/21/2009, 2 pages.

11) Daily notes dated 04/16/2009, 04/20/2009, 05/08/2009, 05/11/2009, provider unknown, 4 pages.
12) MRI report dated 04/30/2009, 1 page.

Patient clinical history [summary]

The claimant is a female with date of birth reported as xx/xx/xx. The reported date of injury was xx/xx/xx. According to IME report of Dr. , the claimant was injured when she slid down into a ditch. The injured regions were reported as low back and right knee. She was reportedly treated by Dr. , Dr. , Dr. , and Dr. She has, reportedly undergone physical therapy (records were unavailable). The claimant was undergone at least 2 prior lumbar epidural injections. The EMG/NCV report dated 05/21/2009 found findings of left L5 radiculopathy. A MRI report dated 04/30/2009 suggested disc pathology at L4-5 and L5-S1. A right knee MRI dated 04/30/2009 found evidence of small amount of fluid and medial meniscus free edge tear. The claimant was rated and determined maximum medical improvement (MMI) on 10/26/2009 with 5% whole person impairment. There was no documentation of significant improvement (50% pain reduction and documented decreased medication use for 6-8 weeks). Post injection. Per report dated 07/08/2009 (Southwest Ohio Pain Institute) the claimant reports only "5 days relief" with recent injection. The purpose of this independent review is to address medical necessity of L5 epidural steroid injection (ESI).

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

Based on review of all submitted documentation and evidence based guidelines the reviewed L5 epidural steroid injection (CPT codes #62311, #77003, #72275) is not medically necessary.

Submitted documentation fails to satisfy inclusion criteria for epidural steroid injection. In particular, criteria (7) and (8) were not satisfied.

There was no documentation of significant pain and functional improvement (50% pain reduction and documented decreased medication use for 6-8 weeks) post injection. Per report dated 07/08/2009 the claimant reports only "5 days relief" with recent injection. Per ODG's "(7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)"

According reviewed documentation; the claimant has already undergone 2 prior injections. Per ODGs "(8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections".

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

Web Based ODG's for Pain Regarding Epidural Steroid Injections:

Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. [Note: This treatment for Low back & Neck pain is primarily covered in those respective chapters.] Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESI's. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. 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. See the Low Back Chapter for more information and references. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral 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, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three". Also see the Neck and Upper Back Chapter.

Sedation: There is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. This is of particular concern in the cervical region. (Hodges 1999) Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. The general agent recommended is a benzodiazepine. (Trentman 2008) (Kim 2007) (Cuccuzzella 2006) While sedation is not recommended for facet injections (especially with opioids) because it may alter the anesthetic diagnostic response, sedation is not generally necessary for an ESI but is not contraindicated. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. Supervision services provided by the operating physician are considered part of the surgical service provided.

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 by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.

2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

3) Injections should be performed using fluoroscopy (live x-ray) for guidance.

4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)

8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.

9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.