



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

DATE OF REVIEW: April 8, 2010

IRO Case #:

Description of the services in dispute:

This is a request for lumbar epidural steroid injections at L3-4, L4-5, and L5-S1.

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

The physician who provided this review is board certified by the American Board of Orthopaedic Surgery. This reviewer is a member of the American Academy of Orthopaedic Surgeons and the Society of Military Orthopaedic Surgeons. This reviewer has been in active practice since 2005.

Review Outcome

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

Based on ODG Guidelines, the request for lumbar epidural steroid injections at L3-4, L4-5, and L5-S1 is not medically necessary.

Information provided to the IRO for review

Records received from the State:

Texas Department of Insurance for IRO dated 03/19/10

Request for a review by an independent review organization dated 03/18/10

Provider that received the denial - not dated

Preauthorization request- notice of non -authorization dated 03/04/10, 02/26/10

Texas Department of insurance notice letter dated 03/22/10

Texas Department of Insurance Notice of Independent review dated 03/22/10

Records received from URA:

Pre-authorization worksheet dated 03/04/10

E-mail for reconsideration dated 03/4/10

E-mail request is denied dated 03/02/10

Received from Provider Office:

Dr. procedure orders dated 02/26/10

MRI & Diagnostic date 03/12/10

Preauthorization request- notice of non -authorization dated 03/04/10, 02/26/10, 02/15/10

Orthopedic report dated 02/02/10

Orthopedic consult dated 01/05/10

Diagnostics - not dated

X-ray cervical - not dated

X-ray right shoulder - not dated

X-ray lumbar- not dated

MRI & diagnostics R Knee dated 12/24/09

MRI & Diagnostics L Knee dated 12/24/09

MRI & Diagnostics L shoulder dated 12/24/09

MRI & Diagnostics R shoulder dated 12/24/09

MRI & Diagnostics Cervical spine dated 12/23/09

MRI & Diagnostics Lumbar spine dated 12/23/09

The Journal of Bone & Joint Surgery dated 2007

effects of spinal steroid injections for degenerative disc disease dated 09/04

epidural steroid injections dated Jan 2004

Nerve Root Block in the Treatment of Lumbar Radicular Pain dated 2006

Criteria for the use of Epidural steroid injections - not dated

Definition of Clinical Findings used to place an individual in a DRE category- not dated

Patient clinical history [summary]

The patient is a male who was being followed for complaints of pain in the lumbar spine and cervical spine. MRI of the lumbar spine, dated 12/23/09, reported a posterior broad-based disc protrusion at the L3-4 and L4-5 levels touching the thecal sac. Moderate foraminal stenosis, bilaterally, was noted. A broad-based posterior disc bulge was also noted L5-S1 along with a subligamentous disc herniation. Hypertrophic changes were noted at the facet joints. These findings combined caused slight neuroforaminal stenosis, bilaterally. No evidence of spondylolisthesis or neoplastic process was noted. The patient was seen by Dr. on 01/05/10. The patient was thrown back from an explosion and had intense pain in the low back. The patient also complained of radiating lower extremity pain. Physical examination reported had blunted patellar and Achilles reflexes with motor strength weakness in the lower extremities. Straight leg raise test was positive for back pain only and tenderness and decreased range of motion of the lumbar spine were noted. The patient was referred for physical therapy and was continued on anti-inflammatory. Radiographs of the lumbar spine were normal. Follow up with Dr. on 02/10/10 stated the patient had some relief with physical therapy. The patient continued to complain of upper extremity numbness and tingling and shoulder pain. The patient also complained of knee pain. Physical examination reported no focal or neurological deficits in the lower extremities. A pre-authorization request, dated 02/26/10, denied service for lumbar epidural steroid injections. No explanation of findings were noted. A second pre-authorization request denied lumbar epidural steroid injections on 03/04/10, as there were no specific findings of nerve root entrapment nor was

there an abnormal lower extremity neurologic exam.

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

The patient's most recent physical examination reveals no focal neurologic deficits that are consistent with the diagnosis of radiculopathy. The MRI study presented for review does not demonstrate any clear evidence of nerve root entrapment, and there are no electrodiagnostic studies available for review that indicate radiculopathy is present in the lower extremities that would warrant the use of epidural steroid injections at this time. Given the insufficient objective clinical evidence of radiculopathy, the request for lumbar epidural steroid injections at L3-4, L4-5, and L5-S1 is not medically necessary.

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

Official Disability Guidelines, Low Back Chapter, online version.

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.)