



DATE OF REVIEW: July 23, 2010

IRO Case #:

Description of the services in dispute: Lumbar Epidural Steroid Injection L2-3

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 Neurological Surgery. This reviewer is a member of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. The reviewer has completed training in both pediatric and adult neurosurgical care. This reviewer has been in active practice since 2001.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be upheld. Medical necessity is not established for lumbar epidural steroid injection L2-3.

Information provided to the IRO for review

- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 07/14/10—5 pages.
- Request for a Review by an Independent Review Organization, dated 07/14/10—3 pages.
- ODG Criteria for the Use of Epidural Steroid Injections—6 pages.
- Correspondence from ESIS Utilization Review, dated 07/09/10—3 pages.
- Correspondence from Health Solutions, dated 07/09/10—3 pages.
- Correspondence from, MD, dated 06/28/10—1 page.
- Office Notes of, MD, dated 06/10/10—2 pages.
- Correspondence from ESIS Utilization Review, dated 06/24/10—3 pages.
- Correspondence from Health Solutions, dated 06/24/10—3 pages.
- Neurosurgical Consultation Preauthorization Request, undated—1 page.
- Office Notes of, MD, dated 06/10/10—2 pages.
- Review of Medical Records by MD, dated 04/16/10—9 pages.
- Procedure Report, Lumbar Epidural Steroid Injection L2-3, dated 09/29/09—1 page.
- Procedure Report, Lumbar Epidural Steroid Injection L2-3, dated 08/04/09—1 page.
- Lumbar Myelogram and CT, dated 11/11/04—1 page.

Patient clinical history [summary]

The patient is a with a history of chronic neck and low back pain. CT Myelogram of the lumbar spine performed 11/11/04 demonstrates L4-S1 fixation with evidence of pseudoarthrosis at L5-S1. The patient underwent lumbar epidural steroid injection on the left at L2-3 on 08/04/09. After 15 minutes, the patient reported the pain was "starting to lighten up." The patient underwent lumbar

epidural steroid injection on the left at L2–3 on 09/29/09. After 20 minutes, the patient stated his low back pain was improved. The request for lumbar epidural steroid injection was denied by utilization review on 07/09/10 due to lack of documentation of an official imaging report identifying concordant imaging pathology. The patient returned for follow up on 06/10/10 with complaints of neck and back pain rated 6 out of 10. The patient is status post C5 to C7 anterior cervical discectomy and fusion in 03/02 and L4 to S1 fusions in 09/03. The patient states the injection performed 09/29/09 provided 60% relief. The patient reports the stinging and burning have returned. The patient would like to have the lumbar epidural steroid injections repeated. Current medications include Amrix and Lidoderm patches. He denies bowel or bladder dysfunction at this time. Physical exam reveals tenderness in the upper trapezial and lower lumbar areas. Straight leg raise is positive bilaterally. Range of motion of the cervical spine reveals forward flexion to 30 degrees, extension to 30 degrees, lateral flexion to the right and left to 15 degrees, and right and left rotation to 45 degrees. Lumbar range of motion reveals forward flexion to 60 degrees, extension to 10 degrees, and lateral flexion to the right and left to 10 degrees. Facet signs are very positive. The patient is assessed with residual neck pain, cervical myofascial pain syndrome, lumbar radiculitis, and residual low back pain. The request for lumbar epidural steroid injection was denied by utilization review on 06/24/10 due to lack of documentation of exam findings in the L3–4 nerve root distribution to support radiculopathy. A letter by Dr. dated 06/28/10 states the patient has chronic hypesthesia in the right L3 and L4 distributions. The patient's need for pain medications has decreased, and he currently uses Tramadol for flare-ups of pain. The letter states the patient's most recent electrophysiological study was prior to his surgery and showed bilateral L5 radiculopathy, but this area has been fused since that time. The patient demonstrates no neurological losses in the L5 distribution.

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

The prior denials for an epidural steroid injection at L2–3 are upheld. The clinical documentation provided for review does not support the request for epidural steroid injections at the L2–3 level. There is insufficient objective clinical evidence of lumbar radiculopathy in an L2–3 distribution to warrant the injections. The only imaging study provided for review is from 2004, and there are no recent imaging studies documenting the presence of neurocompressive pathology at L2–3. The patient is reported to have chronic hypesthesia in the right L3 and L4 distributions; however, there are no EMG/NCV studies or updated imaging studies that are consistent with these findings. Additionally there is minimal documentation regarding efficacy of prior injections at L2–3. The patient is reported to have 60% relief of symptoms from the 09/09 injection at L2–3; however, the time period of relief is not documented. Current evidence based guidelines recommend repeat injections only if there is evidence that the patient had sustained relief from prior injections for at least 6–8 weeks in duration.

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

ODG Low Back Chapter

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.)