



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

DATE OF REVIEW: May 28, 2010

IRO Case #:

Description of the services in dispute: Lumbar Translaminar ESI (#62311, #77003)

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

This physician reviewer is board certified by the American Board of Anesthesiology in General Anesthesiology and Pain Medicine. This reviewer is a member of American Society of Anesthesiology, American Society of Interventional Pain Physicians, and American Society of Regional Anesthesia.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be overturned. Lumbar Translaminar ESI (#62311, #77003) is medically necessary.

Information provided to the IRO for review

Received from the State 05/14/2010:

- Confirmation of Receipt of a Request for a Review by an Independent Review Organization, dated 05/13/2010 - 5 pages
- Request for a Review by an Independent Review Organization, dated 05/11/2010 - 2 pages
- Notification of Reconsideration Determination, dated 04/21/2010 - 4 pages
- Notification of Adverse Determination, dated 04/08/2010 - 5 pages

Received from URA 05/14/2010:

- Office Notes of Dr., dated 05/07/2010 - 3 pages
- Office Notes of Dr., dated 03/31/2010 - 3 pages
- Office Notes of Dr., dated 10/20/2009 - 4 pages
- Office Notes of Dr., dated 09/16/2009 - 4 pages
- Office Notes of Dr., dated 09/02/2009 - 3 pages
- Office Notes of Dr., dated 07/20/2009 - 7 pages
- MRI of the Cervical Spine, dated 05/04/2009 - 1 page
- MRI of the Lumbosacral Spine, dated 09/30/2008 - 1 page
- X-rays of the Lumbar Spine, dated 08/24/2008 - 1 page

Patient clinical history [summary]

The patient is a female who was involved in an accident on xx/xx/xx. Lumbar spine x-rays demonstrated no fracture or subluxation with normal alignment and no significant degenerative change. There was no evidence of spondylolisthesis. An MRI of the lumbar spine revealed mild right neuroforaminal narrowing at L2-3, right paracentral and lateral disc protrusion at L2-3, annular tear with disc protrusion at L4-5, and right foraminal narrowing at L5-S1 from a 2mm concentric disc protrusion and facet arthropathy. On 07/20/2009, the patient began seeing Dr. xxxxx for neck pain, low back pain, and right leg pain. The note indicated the patient had an EMG; however, no results were noted at that visit. On examination, the patient had sciatic notch tenderness on the right with normal motor strength and normal sensory testing. There were muscle spasms in the right paraspinal musculature. Reflexes were 2+ and symmetric. The recommendation was for an epidural steroid injection. On 09/16/2009, a clinical note indicated the patient had 40-50% of low back pain relief with an epidural steroid injection. The patient was doing physical therapy and working in home health. On 03/31/2010, the note indicated the low back pain had completely resolved, but after picking up a heavy object, the patient began having right sided back pain into her buttock and into the anterolateral right leg. The examination revealed an antalgic gait with positive straight leg raise testing at 15 to 20 degrees, and guarding with range of motion. The lower extremities demonstrated 5/5 strength and 1+ bilateral reflexes. There were no sensory changes in a dermatomal distribution. The recommendation was for another epidural steroid injection at L5-S1. On 04/08/2010, a reviewer denied the epidural steroid injection request due to lack of documentation of an increase in performance of activities of daily living and improvement in pain relief as measured by visual analog scale; also, MRI studies were not submitted for review. Reconsideration request was denied; however, from the reviewer comments, it is unclear why the reconsideration was denied.

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

The patient has imaging studies which demonstrate right L5-S1 neuroforaminal narrowing secondary to disc protrusion and facet arthroscopy. The patient had a prior epidural steroid injection at the level requested, and the records indicate 50% relief early on with complete resolution on the notes of 10/20/2009 and 03/31/2010. There was then an incident of lifting that aggravated her back pain with radicular symptoms. The patient's visual analog scale, on 03/31/2010, was 7/10. The examination revealed strong positive right straight leg raise testing and antalgic gait. There was no motor loss or reflex changes. A follow up examination on 05/07/2010 revealed diminished bulk in the right hamstring. The records demonstrate previous therapy and muscle relaxants. The criteria, according to the Official Disability Guidelines, has been met, and the appropriate documentation submitted supports a second injection.

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.)