



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:

Injection, transforaminal epidural; lumbar sacral and fluroscopic guidance.

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 Physical Medicine & Rehabilitation in General Physical Medicine & Rehabilitation and Pain Medicine. 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

The request for lumbosacral transforaminal epidural steroid injection under fluoroscopic guidance is not medically necessary at this time on the basis of a lack of radicular findings.

Information provided to the IRO for review

Records received from the State of Texas:

Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO)
05/19/2010, 5 pages

Request for a Review by an Independent Review Organization 05/18/2010, 3 pages

Adverse Determination Letter 05/4/2010, 2 pages

Adverse Determination Letter 04/13/2010, 2 pages

Records received from Utilization Review Agent:

E-mail Correspondence 05/04/2010, 2 pages

Letter from M.D. 05/18/2010, 2 pages

Letter from M.D. 04/27/2010, 2 pages

Peer Review 40/13/2010, 2 pages

Preauthorization Request 04/18/2010, 1 page

MRI Review Report 04/07/2010, 1 page
Radiology Report 04/06/2010, 1 page
Orthopedics Note 03/24/2010, 2 pages
Orthopedics Note 11/04/2009, 2 pages
Orthopedics Note 09/23/2009, 2 pages
Orthopedics Note 08/19/2009, 2 pages
Orthopedics Note 07/27/2009, 2 pages

Patient clinical history [summary]

The patient is a female who sustained an injury on xx/xx/xx. The clinic note dated 07/27/09 reported the patient was injured when she slipped and fell at work. The patient developed immediate right knee and ankle pain. Radiographs of the right knee taken in clinic revealed lateral tibial plateau fracture with approximately 2.5 mm of depression. The clinic note dated 09/23/09 reported the patient's follow up after a left L5 transforaminal injection. The note reported the patient received 30% pain relief initially and up to 50% pain relief. The clinic note dated 03/24/10 reported the patient developed new symptoms to include pain in the anterior left thigh. The note reported flexion/extension lumbar radiographs revealed a superior endplate vertebral fracture at L5. An MRI of the lumbar spine dated 04/06/10 reported findings of acute superior endplate depression of L3, an old L4 compression, subacute compression of L5 with slight increase of loss of height of the superior endplate of approximately 30%, mild canal stenosis at L4-5 and facet arthrosis at L2-3 and L3-4. The clinic note dated 04/07/10 reported the patient was recommended for a left L4 and L5 transforaminal epidural steroid injection. The prior review dated 04/13/10 reported the request for left L4-5 transforaminal epidural steroid injection was denied secondary to the patient not having radiculopathy. The letter of reconsideration dated 04/27/10 reported the patient received 30% pain relief from the prior left L5 transforaminal epidural steroid injection. The note reported the patient was not a good candidate for a kyphoplasty. The note reported on 03/24/10 the patient had weakness of left hip flexion and radicular left leg pain. The note also reported on 04/07/10 the patient had radiculopathy with pain, numbness and paresthesia in a dermatomal distribution into the anterior lateral thigh and calf consistent with previous radicular pain and injury. The patient again was recommended for epidural steroid injection. The prior review dated 05/04/10 reported the request for a left L4-5 transforaminal epidural steroid injection was denied secondary to lack of radicular findings. The letter of reconsideration dated 05/18/10 reported the patient was being recommended for left L5 transforaminal epidural steroid injection to reduce pain and inflammation and avoid possible surgery. The patient was again recommended for injection therapy.

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

The request for lumbosacral transforaminal epidural steroid injection under fluoroscopic guidance is not medically necessary at this time on the basis of a lack of radicular findings. The clinical documentation submitted for review fails to demonstrate the patient has any current objective clinical findings consistent with lumbar radiculopathy. The practice guidelines recommend that

patients have documented radiculopathy on objective findings before epidural steroid injections are warranted. The documentation does indicate that the patient has received up to 50% pain relief from a prior L5 epidural steroid injection. It is unclear as to the date of service of the previous epidural steroid injection and duration of relief. ODG Guidelines recommend that patients have at least 50–70% pain relief for at least 6–8 weeks before repeat injections are warranted. In consideration of the records and facts presented, there is no supportive evidence to recommend overturning the prior denials. Given the lack of recent objective clinical findings consistent with lumbar radiculopathy, the medical necessity for the request for lumbosacral transforaminal epidural steroid injection under fluoroscopic guidance has not been established at this time.

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

Official Disability Guidelines, 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.)