



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

DATE OF REVIEW: 2/26/10

IRO Case #:

Description of the services in dispute:

Bilateral L5-S1 Epidural Steroid Injection

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 requested bilateral L5-S1 epidural steroid injections are not medically necessary.

Information provided to the IRO for review

Records from State:

IRO Request 2/5/10 - 7 pages

Letter from Health, Inc dated 1/5/10

Letter from Health, Inc dated 12/15/09

Records from URA:

Letter from Texas Department of Insurance 2/9/10

Clinical notes dated 12/03/09-01/20/10

Physical therapy progress note dated 10/16/09

MRI lumbar spine dated 12/09/09

Patient clinical history [summary]

The patient is a female who sustained an injury on xx/xx/xx and is being followed for low back pain. Clinical note dated 12/03/09 states the patient tripped and fell over a desk and developed low back pain. The patient was initially treated with physical therapy for eight sessions and was provided oral medications to include Flexeril, Soma, and Vicodin which did provide some pain relief. Physical examination reports trace reflexes at the Achilles bilaterally. Very mild weakness on right

foot dorsiflexion is noted. Straight leg raise is positive at 45 degrees mildly and sensation in decreased in the left L5 dermatome. The patient was recommended for an MRI study. This was performed on 12/09/09 and reports mild bilateral facet joint arthrosis at L4–5 and mild loss of disc height at L5–S1 with 2mm of retrolisthesis. A broad based disc bulge with anular tearing is noted at this level and there is no evidence of nerve root displacement at the S1 nerve roots. No significant foraminal stenosis is noted and moderate bilateral facet joint arthrosis is present. Physical examination on 12/10/09 is relatively unchanged from the prior examination and the patient was recommended for bilateral lumbar epidural steroid injections at L5–S1. A utilization review determination on 12/18/09 states that the treatment was not medically necessary as there is no indication that the patient is recommended for two transforaminal blocks or that the blocks would be performed under fluoroscopic guidance. A reconsideration determination report on 01/05/10 states the request for bilateral L5–S1 epidural steroid injections were not medically necessary as the MRI study did not reveal evidence of neurocompressive lesions to support a diagnosis at either the L4–5 or L5–S1 levels. The patient was re-evaluated on 01/20/10 with continued complaints of low back pain. No indications of radiating pain are noted. Physical examination is again unchanged from prior examinations.

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

Although the patient has complaints of low back pain radiating to the lower extremities, the MRI study submitted for review does not support the diagnosis of lumbar radiculopathy. The imaging study demonstrates no evidence of significant central canal or neuroforaminal stenosis at either the L4–5 or L5–S1 level that would be consistent with nerve root impingement causing radiculopathy. A small broad based disc bulge is noted at L5–S1; however, as there is no displacement or noted impingement of the nerve roots at this level, the clinical documentation does not meet ODG guidelines regarding unequivocal evidence of radiculopathy. Given that unequivocal radiculopathy cannot be determined for this patient by the clinical documentation, the requested bilateral L5–S1 epidural steroid injections are not medically necessary at this time.

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

Official Disability Guidelines, Online Version, 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.)