



DATE OF REVIEW: April 29, 2010

IRO Case #:

Description of the services in dispute: Lumbar Epidural Steroid Injection L3-4, L4-5

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

The physician who provided this review is a fellow of the American Board of Orthopaedic Surgery. This reviewer is a fellow of the North American Spine Society and the American Academy of Orthopaedic Surgeons. This reviewer has been in active practice since 1990.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be upheld. Medical necessity for the request for lumbar epidural steroid injection at L3-4 and L4-5 is not established at this time.

Information provided to the IRO for review

Received from the State 04/12/2010:

- Confirmation of Request for Review by an Independent Review Organization (IRO) 04/09/2010, 5 pages
- Request for a Review by an Independent Review Organization 04/06/2010, 3 pages
- ODG Guidelines, 3 pages
- Prior Review 03/24/2010, 4 pages
- Prior Review 03/09/2010, 6 pages
- Procedure Orders 03/04/2010, 1 page
- Request for Treatment Authorization Form, undated, 1 page
- Orthopedic Report of Dr. 02/25/2010, 2 pages
- Computerized Muscle Testing/Range of Motion 02/25/2010, 3 pages
- Orthopedic Report of Dr. 01/12/2010, 2 pages
- Electrodiagnostic Evaluation 11/05/2009, 3 pages
- Orthopedic Consult of Dr. 09/28/2009, 4 pages
- Lumbar Spine MRI 07/21/2009, 1 page
- Articles/Abstracts, 12 pages

Received from the Provider 04/16/2010:

- Procedure Scheduling Form 04/12/2010, 1 page

- Procedure Scheduling Form 04/09/2010, 1 page
- Letter from xxxxx Utilization Review Unit 04/09/2010, 2 pages
- Procedure Scheduling Forms 04/09/2010, 2 pages
- Request for Treatment Authorization Form, undated, 1 page
- Surgery Reservation Sheet 04/06/2010, 1 page
- Orthopedic Report of Dr. 03/26/2010, 2 pages
- Computerized Muscle Testing/Range of Motion 03/26/2010, 3 pages
- Letter from ESIS 03/07/2010, 1 page
- X-ray reports 02/25/2010, 03/10/2010, 2 pages
- Letter from Dr., 01/19/2010
- Computerized Muscle Testing/Range of Motion 09/28/2009, 3 pages
- Initial Consultation of Dr. 06/26/2009, 2 pages

#### Patient clinical history [summary]

The patient is a male who sustained an injury on xx/xx/xx. Clinical note dated 06/26/2009 reported the patient was injured when he slipped and fell at work. The note reported the patient complained of pain and discomfort in the cervical spine, thoracic spine, lumbosacral spine, and left knee. The patient also complained of numbness and radiating pain into the left lower extremity. MRI of the lumbar spine dated 07/21/2009 reported minor stenosis of the lateral recess at L3-4 and L4-5 on the left. Electrodiagnostic study dated 11/05/2009 reported evidence consistent with active denervation/reinnervation process involving the left L5 and left S1 nerve roots. Clinical note dated 09/28/2009 reported the patient complained of 8/10 lumbar pain that radiated into the bilateral lower extremities with constant numbness and tingling in the left lower extremity. Physical examination reported 2+ and symmetric deep tendon reflexes, decreased sensation in the lateral leg and dorsum of the foot in the left lower extremity, decreased left lower extremity motor strength compared to the right, tenderness in the left lower lumbar region, decreased range of motion, and positive left straight leg raise. The note reported the patient had diabetes mellitus type II, and injection treatment was recommended after the patient's blood sugars were under control. Clinical note dated 01/12/2010 reported the patient's diabetes was currently under control. The patient complained of 8/10 lumbar pain with occasional numbness and tingling in the bilateral feet. Physical examination of the lumbar spine reported tenderness in the lower lumbar region, decreased range of motion in all directions, decreased sensation in the left lateral leg and left dorsum of the foot, decreased left motor strength compared to right, 2+ and symmetric deep tendon reflexes, and positive left straight leg raise. The patient was recommended for up to date blood work to evaluate diabetes and a lumbar epidural steroid injection. Clinical note dated 01/19/2010 reported that lab results were "in the range I want." Clinical note dated 02/25/2010 reported the patient had received clearance from his endocrinologist. The note reported the patient complained of 7/10 low back pain that radiated to his left lower extremity. The patient was recommended for a lumbar epidural steroid injection. Clinical note dated 03/26/2010 reported the patient complained of 7/10 low back pain that radiated into the left lower extremity with associated numbness and tingling. Physical examination of the lumbar spine reported tenderness in the lower lumbar region, decreased range of motion, decreased sensation along the left lower leg and dorsum

of the left foot, decreased left motor strength compared to the right, 2+ and symmetric deep tendon reflexes, and positive left straight leg raise. The patient was recommended for a lumbar epidural steroid injection.

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

The request for a lumbar epidural steroid injection at the L3–4 and L4–5 level is not medically necessary at this time. MRI of the lumbar spine submitted for review indicates the patient has evidence of mild stenosis of the lateral recess at the L3–4 and L4–5 level on the left. There is no indication of nerve root impingement on the study. The clinical documentation indicates the patient has participated in a physical therapy program; however, no physical therapy notes were submitted for review. The patient was noted to have lumbar spine, cervical, and left knee complaints. It is unclear without physical therapy notes as to what elements were treated with physical therapy sessions. Practice guidelines recommend that patients be unresponsive to conservative care to include physical therapy before lumbar epidural steroid injections are warranted. Additional clinical documentation would need to be submitted to include physical therapy notes before the appropriateness of this request could be established. As such, medical necessity for the request for lumbar epidural steroid injection at L3–4 and L4–5 is not 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, 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.)