

## Notice of Independent Review Decision

**DATE OF REVIEW:** AUGUST 26, 2010.

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar Selective NRB/Transforaminal ESI Left L4-L5 with Fluro Guide, MAC Anesthesia

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

The physician reviewing this case is American Board Certified in Anesthesiology with a secondary specialty in Pain Management.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

On May 5, 2005, an EMG of the left upper/lower extremity was performed. Impression: 1. EMG demonstrates no spontaneous activity or reduced patterns. Recruitment is difficult to judge in the left leg due to lack of voluntary effort. 2. Nerve conduction studies of the left arm and leg are normal as interpreted by M.D.

On March 6, 2006, M.D., P.A evaluated the claimant. Impression: Radiculopathy secondary to Lumbar Disc Displacement, left L4 and left L5 levels. A lumbar selective nerve block/ESI was recommended.

On May 6, 2006, the claimant was re-evaluated by, M.D., P.A. The claimant states the pain is gradually getting worse with associated distal numbness and weakness in the limbs.

On June 6, 2006, , M.D. performed a fluoroscopically guided needed localization of the left L4 and left L5 spinal nerves with transforaminal epidurograms and epidural steroid injections.

On October 23, 2006, the claimant was re-evaluated by, M.D., P.A. The claimant states his pain is markedly better following the transforaminal epidurograms and epidural steroid injections.

On February 21, 2007, the claimant was re-evaluated by, M.D., P.A. The claimant complains of left lower extremity pain in the hip posteriorly, thigh posterolaterally and calf medially and numbness is noted in the great toe.

On March 26, 2007, , M.D., P.A. performed a fluoroscopically guided needle localization of the left L4-5 and L5-S1 facets with arthrograms and diagnostics injection of local anesthetic and steroid.

On July 25, 2007, the claimant was re-evaluated by, M.D., P.A. The claimant states the injection provided moderate relief of symptoms.

On April 21, 2008, the claimant was re-evaluated by, M.D., P.A. The claimant states that the pain is worse with associated distal numbness, weakness in limbs and headache.

On May 9, 2008, , M.D., P.A. performed fluoroscopically guided needle localization of the left L4 and left L5 spinal nerves with transforaminal epidurograms and epidural steroid injections.

On March 2, 2009, the claimant was re-evaluated by, M.D., P.A. Current treatment is proving little relief of current symptoms associated with the transforaminal steroid injections

On March 27, 2009, M.D., P.A. performed fluoroscopically guided needle localization of the left L4 and left L5 spinal nerves with transforaminal epidurograms and epidural steroid injections.

On August 5, 2009, the claimant was re-evaluated by, M.D., P.A. The claimant states that he received an 80% relief of current symptoms associated with the transforaminal steroid injections, lasting 2-3 months.

On August 25, 2009, an EMG of the left lower extremity was performed. Impression: 1. Left L5 radiculopathy. 2. Some evidence for left L4 radiculopathy on this limited as interpreted by, M.D.

On August 26, 2009, x-rays of the lumbar spine were performed. Impression: 1. Multiple level spondylosis and facet arthrosis. 2. Moderate L5-S1 intervertebral disc space narrowing. 3. Lumbar spine appears stable on flexion and extension views as interpreted by, M.D.

On August 26, 2009, an MRI of the lumbar spine was performed. Impression: 1. Mild posterior spondylosis and superimposed 3 mm broad based posterior

protrusion at L5-S1 level, eccentric to the left. 2. Mild central canal stenosis at L4-L5 level. 2 mm broad based posterior protrusion is seen at this level. 3. 1 to 2 mm broad based posterior protrusion at L2-3 level. 4. Moderate bilateral L5-S1 neural foraminal stenosis, left greater than right, and mild right neural foraminal stenosis at the L4-5 level. 5. Multiple level bilateral facet arthrosis. 6. Mild lumbar levoscoliosis as interpreted by, M.D.

On September 9, 2009, the claimant was re-evaluated by, M.D., P.A. Past physical therapy, NSAID's, muscle relaxants have failed to provide any relief. Dr. recommended another transforaminal injection procedure.

On October 14, 2009, , M.D., P.A. performed fluoroscopically guided needle localization of the left L4 and left L5 spinal nerves with transforaminal epidurograms and epidural steroid injections.

On October 28, 2009, the claimant was re-evaluated by, M.D., P.A. The claimant stated he received no relief for his injection 2 weeks prior.

On June 28, 2010, the claimant was re-evaluated by, M.D., P.A. The claimant reports his symptoms are getting worse despite the greater than 50% overall improvement from the injection.

On July 2, 2010, DO, an anesthesiology physician performed a utilization review on the claimant Rational for Denial: The patient had a 10% response to the steroid, which is insufficient as therapeutic response and does not support repeating this injection. MAC anesthesia is no indicated, as the patient has no evidence of unstable medical problems or of uncontrolled anxiety. Therefore, it is not certified.

On July 29, 2010, M.D., an anesthesiology physician performed a utilization review on the claimant Rational for Denial: Insufficient pain relief from the 10/2009 nerve root block. Therefore, it is not certified.

#### **PATIENT CLINICAL HISTORY:**

There was no mechanism of injury given. There is no past medical history or past surgical history submitted. The claimant had a left lumbar transforaminal ESI in 10/09 at L4/5 and noted complete relief with the local immediately but only 10% sustained benefit.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The claimant has had four lumbar epidural steroid injections under appropriate radiological control. Initially, he had marked and sustained improvement from the June 6, 2006, lumbar epidural steroid injection. The March 26, 2007 L4-L5 and L5-S1 facet blocks gave moderate relief of symptoms which is said to continue

on July 25, 2007. On May 9, 2008, a repeat LESI was performed. No relief is described. On March 27, 2009, the third LESI was performed which was reported to give 80% relief of symptoms for two to three months.

Thus the fourth LESI was requested and performed on October 14, 2009. However, this time no significant relief was obtained, with the reported sustained relief of 10% only, as described by, D.O., and , M.D. Therefore, both of these physicians denied a further lumbar epidural steroid injection, based on the lack of relief from the last injection.

**Since no sustained relief was obtained during the last procedure, this independent reviewer finds that the previous adverse determinations should be upheld.** There is no justification for a continuation of lumbar epidural steroid injections, as per the guidelines which state that repeated injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

**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.)

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
  
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
  
- MILLIMAN CARE GUIDELINES
  
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
  
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
  
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)