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Notice of Independent Review Decision

DATE OF REVIEW: 04/06/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Appeal OP Epidural Pain Block at L5-S1 (64483, 64484).

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

Board Certified Neurosurgeon

REVIEW OUTCOME:

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

__x__ Upheld (Agree)

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:

Documentation submitted includes official MRI of the lumbar spine dated 10/28/2011 ready by clinical notes dated 11/10/2011 through 03/20/2012 by official operative report dated 01/17/2012 performed by designated doctor examination dated 01/31/2012 by previous peer reviews dated 02/16/2012 by previous peer review dated 03/19/2012 by cover sheet and other working documents.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with a reported injury on xx/xx/xx. The official MRI of the lumbar spine dated 10/28/2011 read by indicated the patient had levoconvex scoliosis and lumbar spondylosis, with significant lateral recess and foraminal stenosis at the L3-S1 levels. It was also noted the patient had left foraminal lateral broad based protrusion at the L2-3 level with an indeterminate age. The clinical note dated 11/10/2011 by indicated the patient presented with pain in the low back that was noted to be radiating into the left leg and down into the toes with a stated pain level of a 10/10. It was noted the pain was accompanied by numbness in the left leg and was aggravated by walking and standing. It was noted the patient had positive straight leg raise bilaterally. At that time, the patient was recommended for an epidural block at the L5-S1 level. The official operative report dated 01/17/2012 performed by indicated the patient underwent an epidural pain block at the L4-5 space with Depo-Medrol. The clinical note dated 01/31/2012 by indicated the patient stated that the epidural steroid injection had helped for approximately

2 days and reduced the pain by approximately 40%. It was noted the patient continued to have constant pain and numbness in the left leg with prolonged standing. Physical examination noted the patient had spasms in the left paravertebral region. At that time, the patient was recommended for a repeat epidural pain block. The clinical note dated 03/20/2012 revealed that the patient's pain in the low back had not improved and was unable to do much physical activity to include stooping, bending, lifting, and standing due to the pain. It was noted the patient continued to have positive straight leg raise bilaterally and was recommended for an L5-S1 epidural steroid injection.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The documentation provided indicates that the patient tripped and fell over a cord, and had subsequent complaints of back and left leg pain. It was noted the patient had an MRI of the lumbar spine, which indicated the patient had L2-3 left paracentral disc protrusions. At L3-4 there disc osteophyte complexes producing compression in the L4 nerve roots and severe lateral recess stenosis. It was noted the patient underwent an epidural steroid injection at the L5-S1 level that gave approximately 40% decrease in pain for 2 days to 3 days. The peer review dated 02/16/2012 performed by indicated the patient's request for a repeat epidural steroid injection had been decreased due to lack of efficacy from the initial block, as well as no documentation of decreased need for pain medications and improved function. It was also noted that the previous peer review dated 03/19/2012 performed by indicated the repeat request for epidural steroid injection had been denied to due to lack of efficacy from the initial injection. The Official Disability Guidelines state that repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. However, the documentation provided indicates the patient only had a 40% decrease in pain for 2 days to 3 days. The guidelines recommend a 50% to 70% pain relief for 6 weeks to 8 weeks. There is also lack of clinical objective findings of the patient’s increase functional ability to include increased ability to perform activities of daily living and decreased pain medication use. Given the above indications of lack of efficacy of the initial epidural injection the previous determinations are upheld. As such, the request for appeal OP epidural pain block at L5-S1 (64483, 64484) is non-certified.

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

__x__ ODG-OFFICIAL DISABILITY GUIDELINES &TREATMENT GUIDELINES

REFERENCES: Official Disability Guidelines, Low Back Chapter, On-Line Version, Epidural Steroid Injection.
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, reduction of medication use 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. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
(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 supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular 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.)