

**ReviewTex, Inc.**  
1818 Mountjoy Drive  
San Antonio, TX 78232  
(Phone) 210-598-9381 (Fax) 210-598-9382  
reviewtex@hotmail.com

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 03/29/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** ESI (epidural steroid injection) #1  
Injection at L5-S1 CPT: 66483, 64484, A4550, 77003, 62311, 01992.

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

Board Certified Anesthesiologist  
Board Certified Pain Medicine

**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:**

The documentation submitted for review includes clinical notes dated 11/08/2011 through 02/20/2012, designated doctor evaluation by M.D. on 02/21/2012, official MRI's of the lumbar spine, left forearm, and left wrist read by on 12/16/2011, electrodiagnostic study dated 01/24/2012 by M.D., previous peer review dated 11/16/2011 by D.O., peer review dated 02/16/2012 by M.D., previous peer reviewed dated 03/01/2012 by M.D., cover sheet and other working documents.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male with a reported injury on xx/xx/xx. The clinical note dated 11/21/2011 revealed the patient had no significant improvement in the lumbar spine pain. Examination of the lumbar spine noted a moderate amount of pain from L1-L3 bilaterally and severe pain intensity at L4 and L5 and sacrum bilaterally was elicited. At that time, the patient was provided with manual therapy to the low back to provide an increase in functional mobility and decrease pain. The MRI of the lumbar spine dated 12/16/2011 read by M.D. indicated the patient had a 4 mm posterior disc protrusion at L4-L5 and L5-S1, which mildly impinged upon the thecal sac, and also mild narrowing of the lateral recess was noted. It was also noted the patient had 2 mm posterior central disc protrusion at L2-3 and L3-4, which moderately impinged upon the thecal sac. It was also noted the patient had mild disc desiccation from L3-S1 and mild

LHL602 Rev.10/2011

degenerative facet joint hypertrophy from L4-S1. The clinical note dated 01/10/2012 revealed the patient sustained an injury after pushing a grill with an acute onset of low back pain with radiation mainly into the bilateral lower extremities. It was noted the patient was status post physical therapy with no significant improvement, and described the pain level of being a 6/10. Physical examination of the lumbar spine noted lumbar range of motion was decreased in forward flexion secondary to pain, and motor exam revealed a 5/5 strength throughout. It was noted that the patient had straight leg raises that were negative bilaterally and negative Spurling's signs bilaterally. The clinical note dated 02/08/2012 revealed the patient presented with ongoing severe low back pain, with limited range of motion and radicular symptoms down both lower extremities, worse on the right than the left. The patient was noted to have a stated pain level of a 6/10 to 8/10, and stated that the symptoms were exacerbated by Valsalva maneuvers and sitting and standing for long than 5 to 10 minutes. It was noted the patient had completed a course of conservative medical care to include medication, physical therapy, and home exercise program without benefit. At that time, the patient was recommended for an epidural steroid injection to decrease the pain symptoms. The previous peer reviewed dated 02/16/2012 by F. Battle indicated the previous request for an epidural steroid injection had been denied due to inconsistencies between multiple providers on physical exams, and imaging did not show any specific nerve impingement to correlate reported findings and electrodiagnostic testing. The previous peer reviewed dated 03/01/2012 by M.D. indicated the appeal for an epidural steroid injection had been non-certified due to lack of signs and symptoms to support definitive nerve root involvement, and lack of documentation indicating the patient had been unresponsive to conservative treatment.

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

The documentation provided indicated that the patient has had ongoing low back pain, with pain that radiates into the bilateral lower extremities. Physical examinations of the patient's physical exam findings have noted negative straight leg raises bilaterally, and that the patient has 5/5 motor exam throughout. It is noted the patient has attended physical therapy and had manipulation to decrease the pain symptoms without much improvement noted. The guidelines state that a patient must have radicular symptoms that are documented and objective findings on examination as well as the findings being corroborated by imaging studies. It was also noted the patient must be initially unresponsive to conservative treatment. The documentation provided lacks clinical objective findings of radiculopathy to note neurological deficits. Furthermore, there is lack of subjective complaints of tingling and numbing sensations as well as weakness in the lower extremities that may suggest symptoms of radiculopathy. Furthermore, there is lack of documentation to indicate the patient has been initially unresponsive to conservative treatment to include a medication regimen and a home exercise program, as these documents were not submitted for review. Given the lack of documentation, the previous reviews for epidural steroid injection at L5-S1 is upheld, and remains non-certified.

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

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**REFERENCES:** Official Disability Guidelines, Low Back Chapter, Online Version: Epidural steroid injections.

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. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#)) 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.)