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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 02/03/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (in Dates of Service from 12/16/2011 to 12/16/2011

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

Board Certified Orthopedic Surgery of the Spine

**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:**

1. 6/2/08-3/30/09 – Office Notes M.D.
2. 6/6/08 – Surgical Center
3. 9/30/08 -12/3/08 – M.D.
4. 5/14/09 – Upright MRI of LLC
5. 12/3/09-1/4/12 – Orthopedics, Dr. Berliner
6. 3/23/11 – Hospital
7. 9/19/11 – Upright MRI of Clear Lake, LLC
8. 12/16/11 –Peer Review
9. 12/20/11 –Denial
10. 1/12/12 –Denial

**PATIENT CLINICAL HISTORY [SUMMARY]:** This is a male with a reported date of injury of xx/xx/xx. On 06/02/2008, this patient was seen in clinic. He had 1 epidural steroid injection in his back, and he was

requesting 2 more. On exam, knee jerks and ankle jerks were 0. Straight leg raise was positive on the left. He had weakness extensor hallucis on the left and left leg pain to the lateral left thigh. He was undergoing physical therapy at that time. 06/08/2008, this patient was taken to surgery for lumbar epidural steroid injection at L5-S1. On 09/30/2008, this patient underwent bilateral sacroiliac joint injections. On 12/09/2008, this patient underwent bilateral sacroiliac joint injections. On 05/14/2009, this patient had MRI of the lumbar spine. This exam showed mild central disc protrusion at L5-S1, appearing to contact the S1 nerve roots bilaterally. There was mild right and moderate left neural foraminal narrowing seen. There was loss of lumbar lordosis, thought to be secondary to myospasm. On 11/11/2009, this patient had electrodiagnostic testing done. This showed bilateral L5 chronic lumbar radiculopathy without acute process or active denervation, right worse than left. On 12/02/2010, this patient had lumbar x-rays, which were thought to be unremarkable. On 03/23/2011, this patient was taken to surgery for lumbar laminectomy, discectomy and foraminotomy at L5-S1 on the left and right. On 05/03/2011, this patient had x-rays of the lumbar spine, showing that disc space height was reduced at L5-S1. On 09/19/2011, this patient had MRI of the lumbar spine. This examination showed post surgical changes within the dorsal left lumbar soft tissue with evidence of left laminectomy at L5. There was mild compression fracture at the superior endplate of L2 of uncertain acuity. There was mild central disc protrusion at L5-S1, which mildly impressed on the thecal sac and appeared to contact the S1 nerve root bilaterally. There was mild right and moderate left neural foraminal narrowing seen. On 12/09/2011, this patient was seen in clinic. At that time, there was tenderness to the mid and lower lumbar region with decreased range of motion. Straight leg raise was positive for leg pain and back on the left and negative on the right. Motor strength was weakened in the left lower extremity. He had paresthesias in the lateral aspects of both lower extremities into the heels of his feet. He had diminished sensation in both thighs. Motor strength was weakened in his left extensor hallucis longus, as compared to his right. Reflexes were diminished on his left as compared to his right. The request was for lumbar epidural steroid injection and lower extremity EMG.

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

The original utilization review decision dated 12/20/2011 indicates that when clinical notes were reviewed, there was no radiculopathy objectively identified by EMG. The patient had already had 3 epidural steroid injections without significant relief. The subsequent review dated 01/12/2012 indicated that there was no evidence of acute radiculopathy, as the claimant had undergone electrodiagnostic testing which revealed no evidence of acute radiculopathy. Furthermore, it was noted he had undergone 3 previous epidural steroid injections without significant relief, and guidelines do not support repeat injections without evidence of at least 50% to 70% pain relief for at least 6 to 8 weeks. The submitted records for this review indicate that this patient has radiculopathy on physical exam with decreased strength in the left lower extremity with paresthesias in the lateral aspect of both lower extremities, with diminished sensation along both thighs. However, the requested EMG was not provided for this request to objectively identify radiculopathy. Therefore, the request is not considered reasonable and necessary.

**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, 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, 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

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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.)