



**MEDICAL EVALUATORS
OF TEXAS ASO,LLC.**

1225 North Loop West • Suite 1055 • Houston, TX 77008
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

DATE OF REVIEW: JULY 5, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar Epidural Steroid Injection #1 at L4-5 and L5-S1 (62311)

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

This case was reviewed by a board certified anesthesiologist with a subspecialty in pain management and has been licensed in the State of Texas since 1992.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Type of Document Received	Date(s) of Record
MRI of the lumbar spine	04/26/2012
A letter from MD	05/17/2012
A letter of reconsideration by MD	05/18/2012
A follow up consultation by DO	05/30/2012
Manual muscle strength exam by MD	05/30/2012
A letter from Worker's Services for request of IRO for denied service of "Lumbar Epidural Steroid Injection #1 at L4-5 and L5-S1"	05/31/2012
A follow up visit by MD	06/07/2012
A follow up evaluation by DC, PA	06/15/2012

EMPLOYEE CLINICAL HISTORY [SUMMARY]:



**MEDICAL EVALUATORS
OF TEXAS** ASO,LLC.

1225 North Loop West • Suite 1055 • Houston, TX 77008
800-845-8982 FAX: 713-583-5943

This is a male who sustained an injury on xx/xx/xx when he picked up a heavy box and turned feeling pain in his lower back with pain radiating to his left leg. He then had MRI of lumbar spine. He was evaluated by Dr. and was treated with physical therapy. He was seen by Dr. on 05/30/2012 who recommended lumbar ESI. On 06/07/2012, he was seen by Dr. MD who also recommended lumbar ESI. On 06/15/2012, he was seen by Dr. who stated the examinee ultimately will require surgical intervention.

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

The patient fulfills the ODG criteria for epidural steroid injection:

Criteria for ESI include documented radiculopathy and initially unresponsive to conservative treatment. These criteria are documented in note dated 6/07/12 by who notes:

“Mr. is seen back in the office on June 7, 2012. He completed a course of physical therapy, which did not give him sustained relief.” and ... “Examination today shows 45 degrees of flexion. He has pain with straight-leg raising at 30 degrees. There is normal strength in the iliopsoas and quadriceps; but there continues to be weakness in the left tibialis anterior, extensor hallucis longus, gastrocnemius, and soleus group. The left ankle reflex is absent. There is atrophy of the left calf by 2.5 cm.”

In addition, nerve root compression concordant with the signs and symptoms has been documented on the MRI of the lumbar spine dated 04/26/12:

L4-5 advanced loss of disc signal, moderate loss of disc height. There is an approximately 6mm- 7mm slightly left sided disc protrusion/herniation, Herniated disc material also extends approximately 6mm below, as well as approximately 5mm above the disc level to the left of midline. The anterior margin of the thecal sac is contacted and partially effaced. There is moderately severe compromise of the left lateral recess at the L4-5 disc level, as well as to a lesser degree at the inferior aspect of L4 and the superior aspect of L5. There is compression of the L5 nerve root. There is also moderate compromise of the right lateral recess with contact of the right LS nerve root. The neural foramina are also moderately encroached bilaterally. The exiting dorsal root ganglia are surrounded by a thin rim of fat.

L5-S1 advanced loss of disc signal with a large slightly left sided disc protrusion/herniation. Herniated disc material extends approximately 9mm-10mm posterior to the cortical margin, approximately 4-5mm above, as well as below the disc level, The anterior margin of the thecal sac is contacted and partially effaced. The spinal canal is stenotic at 9-10 mm. There is severe compromise of the left lateral recess, moderately severe compromise of the right lateral recess, as well as moderately severe compromise of the neural foramina bilaterally with compression of the exiting L5, which will likely result in at least S1, as well as L5 radicular type symptoms.



**MEDICAL EVALUATORS
OF TEXAS ASO, LLC**

1225 North Loop West • Suite 1055 • Houston, TX 77008
800-845-8982 FAX: 713-583-5943

The criteria for the use of epidural steroids has been met and therefore, the decision to deny the Lumbar ESI should be overturned.

ODG 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,



**MEDICAL EVALUATORS
OF TEXAS ASO,LLC.**

1225 North Loop West • Suite 1055 • Houston, TX 77008
800-845-8982 FAX: 713-583-5943

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)