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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 7/6/2012

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); Lumbar or sacral, single level.

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

The reviewer is a Medical Doctor who is board certified in Anesthesiology.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); Lumbar or sacral, single level.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source):

- Records reviewed from
  - Denials- 4/26/12, 5/16/12
- Medical Review Institute of America, Inc.
  - Peer Reviews- 4/26/12, 5/15/12

M.D.

Office Notes- 4/24/12  
Medical Center  
MR Lumbar Spine w/o Contrast- 3/22/12

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is a female who was injured xx/xx/xx. MRI dated 03/22/2012 reveals findings of diffuse disc bulge at L4-5 causing mild spinal canal and moderate neural foraminal narrowing bilaterally. The patient was also noted to have moderate disc desiccation at L5-S1 with endplate changes, diffuse disc bulge with right foraminal and far lateral disc protrusion causing mild spinal canal and moderate left neural foraminal narrowing. The patient was also noted to have moderate to severe right foraminal at L5-S1 and contact of the exiting L5 nerve root bilaterally. The clinical note dated 04/24/2012, reported that the patient complained of 9/10 low back pain with radiation into the right lower extremity. The note reported that prior conservative treatment including acetaminophen, heat pad, muscle relaxant and oral corticosteroids with little relief. The physical examination revealed symmetric reflexes, 5/5 motor strength, 10 degrees of flexion, 0 degrees of extension and positive bilateral straight leg raise. The patient was recommended for a right L5 and S1 transforaminal epidural steroid injection.

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

Official Disability Guidelines: Low Back Chapter - Epidural Spinal Injections Therapeutic.  
Epidural steroids injections (ESIs), therapeutic:

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
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 percent 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 regions 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' injection 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 injections 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.)

The request is for transforaminal epidural steroid injection at right L5 and S1 not medically necessary at this time. The patient complains of low back pain with radiation into the lower extremities. The patient has been treated with conservative measures including steroids, acetaminophen, heating pads and muscle relaxants. However, there is no mention of physical therapy in this patient's care. Additionally, there are not documented neurologic deficits consistent with radiculopathy that would indicate the need for an epidural steroid injection at this time. Therefore, the current request is not medically necessary.

**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)