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**Notice of Independent Review Decision**

**DATE OF REVIEW:**\_ 03/21/2012

**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  
Reconsideration request receipt date: 02/03/2012

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

Board Certified Pain Medicine, Board Certified Anesthesiology

**REVIEW OUTCOME**

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

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:**

Clinical notes dated 11/14/2003 through 02/27/2012 by operative report dated 07/21/2010 performed by MRI of the lumbar spine dated 10/05/2010 read by, clinical note dated 10/28/2010 by, peer review reported dated 01/19/2012 by, peer review reported dated 02/03/2012 by, and cover sheet.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male with a reported injury on xx/xx/xx. The clinical note dated 11/14/2003 revealed the patient presented with persistent axial back, bilateral buttock, and right lower extremity pain following a work related injury. It was noted the patient had utilized physical therapy and epidural steroid injections with only temporary relief. The patient was noted to have a stated pain level of a 7/10 to 8/10. It was noted range of motion was diminished secondary to pain, and straight leg raises were positive on the right. At that time, the patient was recommended for epidural steroid injection therapy to decrease the pain symptoms. The clinical note dated 06/03/2010 revealed the patient reported a more than 50% improvement to the back, buttock, and leg pains following epidural steroid injection therapy #2. The patient stated that he diminished the medication use by half, and was able to lift, bend, and go about routine of daily activities. The MRI of the lumbar spine dated 10/05/2010 revealed the patient had left posterolateral disc extrusion at the L1-L3 levels with moderate spinal canal stenosis noted. It was noted the patient had moderate to severe spinal canal stenosis at the L4-L5 level. The clinical note dated 07/21/2011 revealed the patient was able to perform activities of daily living, and was working on a weight loss and exercise therapy program. It was noted the patient had mild to moderate back pain with lumbar flexion and moderate intraspinous tenderness, as well as positive straight leg raises bilaterally. At that time, the patient was recommended for epidural steroid injections due to having ongoing use of weak

narcotic analgesic on a steady basis in conjunction with Neurontin therapy. The clinical note dated 01/12/2012 revealed the patient had moderate back lumbar pain associated with right lumbar radiculopathy and positive straight leg raises. It was noted the patient had decreased pinprick sensation at the L5-S1 distribution extending to the L4 distribution, and was recommended for an epidural steroid injection. It was noted the patient had moderate lumbar intraspinous tenderness and a mild positive straight leg raise, and was recommended to continue with hydrocodone and Neurontin. The clinical note dated 02/27/2012 revealed the patient's previous epidural steroid injection was over 2 years prior, and has had pain with coughing, sneezing, and bearing down in the lumbar spine again. It was noted the patient wished to reinstitute a lumbar epidural blockade. It was noted the patient was utilized NSAIDS, as well as a weak narcotic analgesia on a steady state basis. It was noted the patient had mild decreased pinprick sensation in the L4 distribution on the right. The patient had a stated pain level of 7/10 to 8/10. The previous peer review dated 01/19/2012 by. indicated the request for the lumbar ESI was non-certified due to no injection history documenting the percentage of benefit received from previous epidural steroid injections. The peer review dated 02/03/2012 by. indicated the request for a lumbar ESI was non-certified due to lack of comprehensive assessment of treatment and lack of objective and functional response to previous injections.

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

The patient is noted to have ongoing low back pain that radiates into the lower extremities, most recently with a stated pain level of a 7/10 to 8/10. It was noted that the patient has previously been treated with epidural steroid injections over 2 years ago, in which the patient had a 50% pain relief with medication reduction. It was noted the patient had positive straight leg raises bilaterally. It is noted the patient underwent a lumbar epidural steroid injection on 07/21/2010; however, the efficacy of that injection is unknown. The MRI of the lumbar spine dated 10/05/2010 revealed the patient had congenital spinal canal stenosis at L2-L5 with shortened pedicles in the anterior and posterior dimension. It is also noted the patient had moderate to severe spinal stenosis at L2-L5 levels. The most recent clinical note indicated the patient had mild decreased pinprick sensation at the L4 distribution on the right. The guidelines state that repeat injections may be indicated if the previous injections provided at least 50% to 70% pain relief for 6 to 8 weeks, and there is documented pain relief, documentation of decreased need for pain medications, and functional response; however, the documentation provided lacks indications as to the efficacy of the most recent epidural steroid injection on 07/21/2010 noting at least a 50% to 70% pain relief and decreased medication use. Furthermore, there is lack of documentation to note the patient's functional increases to include return to work or increased ability to participate in activities of daily living due to the most recent injection. Furthermore, the request is very nonspecific and does not indicate at which level or levels the injection is to be administered. Given the above indications, the request cannot be substantiated. As such, the request for injection, single, not including neurolytic substances, with or without contrast, of diagnostic or therapeutic substances is 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. 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.)