

**IRO REVIEWER REPORT TEMPLATE -WC**

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**Notice of Independent Review Decision**

**Date notice sent to all parties:**

April 9, 2013

**IRO CASE #:**

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

Left L5-S1 Lumbar Epidural Steroid Injection with Fluoroscopy.

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

Board Certified Neurologist, Board Certified Pediatrician

**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 medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. 12/11/1991, Lumbar Myelogram Report, MD.

2. 11/18/1991, 12/09/1991, 01/13/1992, 02/20/1992, 06/04/1992, 07/30/1992, 08/20/1992, Progress Notes, MD.
3. 06/04/1992, Chest X-ray, MD.
4. 06/09/1992, Lumbar Laser Disc Decompression Procedure Report, MD.
5. 06/09/1992, History and Physical, MD.
6. 06/09/1992, C-Arm Fluoroscopy Report, MD.
7. 08/21/1992, MRI Report, Lumbar Spine, MD.
8. 10/27/1992, Lumbar Myelogram Report, MD, MD.
9. 12/08/1992, Chest X-ray Report, MD.
10. 12/11/1992, Right L4-5 Laminectomy with Excision of Herniated Disc, Procedure Report, MD.
11. 12/11/1992, History, MD.
12. 12/11/1992, History and Physical, MD.
13. 12/11/1992, X-rays Lumbar Spine, MD.
14. 12/14/1992, Bladder Volume Study, MD.
15. 12/11/1992, Pathology Report, MD.
16. 09/03/1992, 10/15/1992, 01/07/1993, 03/23/1993, Progress notes, MD.
17. 04/30/1993, Lumbar Myelogram Report, MD.
18. 08/23/1993, Chest X-ray Report, MD.
19. 08/27/1993, Discharge Summary, MD.
20. 08/27/1993 Operative Report, MD.
21. 08/27/1993, Radiology Report, Lumbar Spine, MD.
22. 08/29/1993, Pathology Report, MD.
23. 09/20/1993, Lumbar Spine X-ray Report, MD.
24. 12/06/1993, Radiology Report, MD.
25. 04/26/1993, 05/06/1993, 08/05/1993, 09/20/1993, 10/11/1993, 12/06/1993, 01/06/1994, Progress Notes, MD.

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26. 02/18/1994, Lumbar spine X-ray Report, MD.
27. 02/17/1994, 03/31/1994, 05/26/1994, 07/28/1994, Progress Notes, MD.
28. 11/10/1994, MRI Report Lumbar Spine, MD.
29. 08/21/1995, 12/21/1995, 03/28/1996, Progress Notes, MD.
30. 10/31/1994, 12/08/1994, 01/19/1995, 04/20/1995, 08/01/1996, 12/09/1996, 06/23/1997, Progress Notes, MD.
31. 09/19/1997, Lumbar Myelogram Report, MD.
32. 09/19/1997, Radiology Report, MD.
33. 08/28/1997, 10/23/1997, 11/17/1997, 01/26/1998, Progress Notes, MD.
34. 11/10/1999, Lumbar Spine X-ray Report, MD.
35. 04/02/1998, 05/21/1998, 07/13/1998, 08/24/1998, 10/01/1998, 11/12/1998, 01/14/1999, 03/01/1999, 04/12/1999, 06/03/1999, Progress Notes, MD.
36. 11/10/1999, Discharge Summary, MD.
37. 11/10/1999, Operative Report, MD.
38. 11/10/1999, History and Physical, MD
39. 08/30/1999, 11/08/1999, 12/09/1999, 02/14/2000, 04/17/2000, 08/03/2000, 10/12/2000, 12/14/2000, 10/11/2001, 05/23/2002, 11/21/2002, 05/29/2003, 11/20/2003, 07/29/2004, 01/27/2005, 07/14/2005, 01/12/2006, 07/06/2006, 07/24/2006, 12/13/2006, 12/21/2006, Progress Notes, MD.
40. 12/09/1999, Radiology Report, MD.
41. 12/14/2000, Lumbar Spine X-ray Report, MD.
42. 10/12/2000, Lumbar Spine X-ray Report, MD.
43. 07/17/2000, Surgical Followup X-ray Report, MD.
44. 04/17/2000, X-ray Report, MD.
45. 02/14/2000, X-ray Report, MD.
46. 03/06/2008, 07/14/2008, 10/11/2008, 03/16/2009, 08/06/2009, 11/05/2009, 02/04/2010, 05/06/2010, 05/20/2010, 06/07/2010, 09/02/2010, unstated date, 03/03/2011, 06/02/2011, unstated dates in 09/2011 and

11/2011, 05/31/2012, 09/06/2012, 12/17/2012, and unstated date, Progress Notes, MD.

47. 01/02/2013, CT Lumbar Spine, MD.

48. 01/16/2013, Request for Procedures, Lumbar Epidural Steroid Injection.

49. 02/15/2013, 01/22/2013, Utilization Review Determinations, .

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant is a male with low back pain. On 12/11/1991, a lumbar myelogram report was submitted indicating there was a small central L4-5 defect. Exam was read by MD. On 06/09/1992, he underwent lumbar L4-5 laser disc decompression by MD. On 08/21/1992, an MRI of the lumbar spine was obtained indicating at L5-S1 there was difficulty for assessment. This was thought to be secondary to a conjoined nerve root on the side at that level. There was disc degeneration at both L4-5 and L5-S1 discs with loss of signal on T1 weighted images. There was no significant loss of height to the disc and there were slight central bulges at both of those levels. On 12/11/1992, this claimant was taken back to surgery for a right L4-5 laminectomy with excision of herniated disc under microscopic control by MD. He is followed up serially and then on 04/30/1993, a lumbar myelogram was performed with findings consistent with disc herniation at L4-5 in a right paracentral location. That exam was written by MD. On 08/27/1993, this claimant underwent bilateral L4-5 total discectomy for a recurrent disc with nerve root decompression microscopic and an L4-5 interbody fusion bilaterally performed by MD. He is followed up serially through 1993 and 1994. On 11/10/1994, an MRI of the lumbar spine was obtained showing an intradiscal graft on the left at L4-5. There was enhancing material separating the thecal sac from the disc margin. There is no distinct disc herniation following enhancement. Bilateral partial laminectomies were performed at L4-5. There was some impression upon the thecal sac to the left at L5-S1. No distinct disc herniation was seen at that level. Exam was read by MD. From 08/21/1995 through 1997 he was followed up by Dr. On 09/19/1997, he underwent a lumbar myelogram. This exam revealed previous laminectomy at L4-5 and a lateral extradural indentation of the thecal sac was seen on the right at L4-5 with some slight upward displacement of the exiting nerve root at that level. That exam was read by MD. The claimant was followed up through 1997, 1998, 1999 by Dr.. On 11/10/1999, he was taken back to surgery for a decompression of bilateral lumbar L4 and bilateral L5 nerve roots with opening in lateral recesses and foraminotomies with a posterolateral lumbar fusion at L4-5 performed by Dr. The claimant was followed up serially through 1999, 2000, 2001, 2003, and 2006 by Dr. He was subsequently followed up in 2008, 2009 and 2010 by Dr. He was followed up serially through 2011 and 2012 by Dr. In 01/2013, on unstated date due to poor copy quality, he was seen and had rather severe lumbosacral spine pain with bilateral hip and leg radiating pain, mainly on the left. Straight leg raise was positive bilaterally at less than 45 degrees. He had a left antalgic gait and a lumbar CT scan

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showed foraminal constriction mainly at L5-S1 with bilateral foraminal stenosis but no severe central canal stenosis was seen. He was taking Ultram and Motrin at that time. It was noted he had excellent results in the past with epidural Depo-Medrol injections and therefore, another 1 was requested at that time.

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

On 01/22/2013, an adverse determination was submitted for the requested left L5-S1 lumbar epidural steroid injection under fluoroscopy. The rationale provided for that review indicates that the submitted medical records indicate that previous epidural injections gave the patient excellent relief, reduced his need for medications and made him more functional. However, there was no objective documentation of the degree and duration of the reported pain relief and functional improvement. The submitted records also noted the epidural injections had been repeatedly requested and denied since 2006. There was some note of positive findings on the physical exam. There are no significant deficits to indicate radiculopathy at the level of the requested ESI. The provided imaging study also did not contain findings that corroborated radiculopathy to substantiate the requested procedure. As such, the medical necessity of the requested left L5-S1 lumbar epidural steroid injection under fluoroscopy was not established and the request was non-certified. An appeal decision dated 02/15/2013 also concluded that there was lack of documentation to support continued objective documented pain relief, decreased need for pain medications and functional response submitted for review and the request was not supported. Dates and levels of injections were not stated. Guidelines recommend repeat injections be based on continued objective documented pain relief, decreased need for pain medications and functional response. As this was not provided, the request was non-certified.

The additional records submitted for this review also fail to document significant relief from the previous injections. The CT scan dated 01/02/2013 does indicate that at L5-S1 there is loss of disc height with disc vacuum phenomenon and moderate facet disease with mild disc bulge. There was moderate bilateral foraminal stenosis without significant spinal stenosis. As such, the functional improvement that is needed to objectively document relief from the previous injections was not provided for this review as previously stated on the 2 utilization determinations. Therefore, the initial determination dated 01/22/2013 is correct in their findings and the appealed determination on 02/15/2013 is also correct in their findings and the request is not supported.

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### 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**

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

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.

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(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.)