



**MEDICAL EVALUATORS
OF TEXAS** ASO, L.L.C.

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

Notice of Independent Review Decision

DATE OF REVIEW: March 25, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Epidural Steroid injection under fluoroscopy with IV Sedation, #62311, #77003

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

This case was reviewed by a physician board certified in Physical Medicine and Rehabilitation currently licensed and practicing in the State of Texas.

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	04/19/2011
EMG/NCS of lower extremities	08/31/2011
Follow up report	02/23/2012
CT myelogram of lumbar spine	03/19/2012
Initial evaluation report	07/16/2012
Follow up report	09/10/2012
Follow up report	11/08/2012
Follow up report	01/07/2013
Follow up report	01/14/2013
A letter regarding treatment request	01/07/2013
A letter of denial	01/07/2013
A letter regarding reconsideration of	01/17/2013



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treatment request	
A letter regarding reconsideration of treatment request	02/01/2013
A letter of denial	02/01/2013
Follow up report	03/05/2013
A request for an IRO for denied services of "Lumbar Epidural Steroid injection under fluoroscopy with IV Sedation, #62311, #77003"	03/15/2013

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a female who sustained work-related injury to her lower back on xxxx while picking up heavy object. She reported she felt a pop in her lower back with pain radiating down her leg associated with numbness, tingling, and weakness. She was evaluated and was treated with physical therapy. She then had MRI of the lumbar spine that showed disc protrusion at L4-5 projected into the spinal canal. Subsequently, she had an EMG done on 08/31/2011 that showed right L5 and S1 radiculopathy. She was then treated with ESI x1. She continued to have lower back pain with radiation down her legs. Since July 2012, she was under care who has now recommended lumbar ESI at L4-5 level.

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

An epidural steroid injection is appropriate and supported by the ODG and the clinical examination. This claimant has evidence of radiculopathy on physical examination. MRI shows a disc protrusion. EMG shows L5-S1 radiculopathy. There was injection therapy in the past and no clear documentation of response. She has been unresponsive to conservative treatment such as physical therapy.

Therefore, it is my opinion that the request for lumbar ESI under fluoroscopy with IV Sedation at L4-5 level is medically appropriate and necessary.

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).



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- (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.)



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**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)