



Claims Eval

Notice of Independent Review Decision

August 21, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection @ L5-S1 using fluoroscopy

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

American Board of Physical Medicine and Rehabilitation; Subcertification in Pain Medicine

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)

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:

- 3-22-13, x-rays and MRI of the lumbar spine
- 4-11-13, EMG/NCV

- 4-29-13, office visit
- 5-7-13, procedure orders
- 5-13-13, Adverse Determination Letter
- 6-21-13, Adverse Determination Letter
- Request for cervical epidural steroid injection on 6-26-13

PATIENT CLINICAL HISTORY [SUMMARY]:

3-22-13 X-rays of the lumbar spine, showed no evidence of fracture or subluxation. The disc spaces are preserved. There is posterior osteophyte at L5-S1 causing narrowing of the central canal. There is facet arthropathy at this level. MRI of the lumbar spine showed a 2.5 mm broad based disc protrusion with short pedicles causing narrowing of the central canal and lateral recesses at L4-5 and L5-S1. Disc bulge at L2-3 and L3-4. Slight narrowing of the central canal at L3-4 abutting the thecal sac.

4-11-13 EMG/NCV, showed evidence of a mild bilateral carpal tunnel syndrome affecting the sensory and motor components of the nerves. Evidence of L5 and S1 radiculopathy on the left. Evidence of C6-7 nerve root irritation on the left.

4-29-13, the claimant presents with complaints of pain in the lumbar region. She states the glass of a nearby window shattered. She ran down the stairs and fell to the ground to her right side. On the next day she woke up with worse pain in her neck, back, right shoulder, right elbow and right ankle. She complains of cervical pain that she rates a 4/10 and radiates to both of her shoulders. She also has complaints of pain in the lumbar region that she rates a 6/10 and radiates to her buttock, posterior thigh and calf. She also has a history of pain in the right elbow that she rates a 0/10. She has a history of pain in the right shoulder that she rates a 0/10. She has a history of pain in the right ankle that she rates a 0/10. Exam shows ¼ patella reflex bilaterally. Sensation altered at S1 on the left. She has mild spasm and paracervical tenderness. Triceps reflex ¼ bilaterally. Positive Spurling's. Lumbar tenderness and mild spasm present. Limited lumbar lateral flexion. Sensation altered at left S1. SLR on the right with back pain only and on the left with leg pain to foot. Impression: Lumbar disc displacement. Cervical disc displacement. Plan: Recommended cervical ESI. Lumbar activity modification.

5-7-13 is requesting LESI.

5-13-13, non certification for epidural steroid injection at L5-S1. The clinical examination is not confirmatory for any reflex or motor defect. The request is not confirmed as a medical necessity.

6-21-13, non certification for epidural steroid injection at L5-S1. At this time, there is lack of objective evidence of a lumbar radiculopathy. Although electrodiagnostic studies accomplished during the work-up documented a left L5 and S1 radiculopathy, the physical examination findings document normal strength and normal deep tendon reflexes in the bilateral lower extremities. The only abnormal finding is a positive straight leg raise test and altered sensation in the left S1 distribution. At this time, the physical examination findings do not support clinical evidence of a lumbar radiculopathy. There is also no documentation of any significant neurocompression on the imaging studies. The treating provider is requesting to proceed with cervical epidural steroid injection as well. Based on treatment guidelines, epidural steroid injection accomplished at the same time for the cervical spine and lumbar spine are not supported. The medical records do not indicate that these injections are being performed at different times; therefore, the request cannot be certified at this time. The previous non-certification was based on the fact that the clinical examination findings were not confirmatory of any reflex or motor deficit and therefore, the request was not certified. The treating provider has not provided any additional information that would result in an overturn of the previous non-certification. Again, performing cervical epidural steroid injection at the same time as lumbar epidural steroid injections is not supported and there is no indication that these are going to be done at different times. The reconsideration request for lumbar epidural steroid Injection at L5-S1 using fluoroscopy is not certified.

Request for cervical epidural steroid injection on 6-26-13.

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

Medical records reflect the request for L5-S1 epidural steroid injection. The problem with this request is that there is an absence in documentation of radiculopathy present, per ODG. Based on the records provided, this claimant does not meet current guidelines for the definition of radiculopathy. There is no indication of atrophy or absent reflexes. Therefore, the request for lumbar epidural steroid injection @ L5-S1 using fluoroscopy is not reasonable or medically necessary.

Per ODG 2013 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.)

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)**