

# CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: August 27, 2013

**IRO CASE #:**

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

Lumbar Epidural Steroid Injection

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 16 years of experience.

**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:**

01/29/13: MRI Lumbar Spine  
03/04/13: MIR Pelvis  
04/08/13: Report of Medical Evaluation  
04/29/13: EMG/NCS of the lower extremities  
05/16/13: Initial FCE  
06/06/13: Follow-up Evaluation  
07/02/13: Initial History and Physical  
07/09/13: UR performed  
07/18/13: Follow-up Evaluation  
07/22/13: History and Physical  
07/30/13: UR performed

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who was injured on xx/xx/xx after she fell off a chair.

On January 29, 2013, MRI Lumbar Spine, Impression: 1. Minor lumbar scoliosis convex to the left with disc desiccation at L2-3, L4-5 and L5-S1. 2. Minor disc space narrowing at L2-3 and L4-5. 3. Circumferential 2.2 mm disc bulge with minor bilateral neural foraminal narrowing at L2-3. 4. Bilateral lateralizing 1mm disc bulge with minor right neural foraminal narrowing at L3-4. 5. Circumferential 2.2 mm disc bulge with early facet hypertrophic changes at L4-5. Minor to mild bilateral neural foraminal narrowing. 6. Broad-based 1.5 mm disc bulge with early facet hypertrophic changes at L5-S2. Mild bilateral neural foraminal narrowing.

On March 4, 2013, MRI Pelvis, Impression: 1. No evidence for a sacral, coccygeal or pelvic fracture. 2. Midline gluteal subcutaneous edema/mild contusion. 3. Mild edema posterior to the coccyx likely indicating contusion.

On April 29, 2013, EMG/NCS, Impression: No electrophysiological evidence of lumbar radiculopathy, lumbosacral plexopathy, or distal mononeuropathy was recorded in these electrodiagnostic studies of the lower extremities.

On June 6, 2013, the claimant was re-evaluated for tailbone and low back pain radiating down the right lower extremity with numbness and tingling. Her pain level was rated a 7. She indicated difficulty with prolonged sitting and had to sleep in her husband's recliner because lying flat causes more discomfort. It was noted that a recommended work hardening program was denied. On physical examination the back and sacrum were unchanged and neurological exam was also noted as unchanged. (Previous records with exam findings were not provided for review.) Gait was noted to be slightly slow paced. Assessment: 1. Sacral/coccyx contusion. 2. Lumbosacral strain/sprain. 3. Rule out right lower extremity neuropathy. 4. Right knee strain/sprain. Recommendation: Continue home exercise program and waling exercises. Continue current medications. Referral for evaluation for interventional procedures.

On July 2, 2013, the claimant was evaluated for low back and right leg pain. She described severe pain over the tailbone, such that sitting was painful; and she also had low back pain along the beltline radiating down the right leg to the lateral foot. She reported tingling and numbness in that distribution with weakness in the knee and ankle. It was reported physical therapy had not been successful. On physical examination ROM was decreased with pain. Babinski was negative bilaterally. Straight leg raise was normal on the left, abnormal on the right. Patellar DTR was 2/4 on the left, ¼ on the right. Achilles DTR was 0/4 bilaterally. Sensation was decreased in the L5 distribution. Strength was 5/5 except for right Quadriceps and EHL were 4/5. Diagnosis: Lumbar Radiculitis. Plan: Diagnostic/therapeutic lumbar epidural steroid injection under fluoroscopy. May consider doing a second epidural steroid injection.

On July 9, 2013, performed an UR. Rationale for Denial: The request is nonspecific and does not indicate the level, laterality or approach to be utilized. The submitted MRI does not document any significant neurocompressive

pathology and the EMG/NCV provided notes no evidence of lumbar radiculopathy. Current evidence based guidelines require corroboration by imaging studies and/or electrodiagnostic results. Attempts at peer discussion were not successful.

On July 18, 2013, the claimant was re-evaluated for continued low back pain radiating down the right lower extremity with numbness and tingling. Her pain was rated at a 9. It was reported that she had to use her pain medication more frequently, even up to every 3-4 hours. wanted to continue her on the Neurontin, Flexeril and add Cymbalta to help with her pain symptoms. On physical exam she had difficulty getting from sitting to standing position, and walked with an antalgic gait due to pain symptoms.

On July 30, 2013, performed an UR. Rationale for Denial: Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. The claimant has undergone EMG which did not show radiculopathy in this claimant. No clear documentation showing why this procedure should be performed when the claimant does not meet the requirements of the ODG for the requested treatment.

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

Denial of Lumbar Epidural Steroid Injection is upheld/agreed upon since there is no specific spinal level requested so there is no ability to correlate the assumed radiculopathy with presented history, exam and imaging studies at that level. The electrodiagnostic studies were also negative for radiculopathy at any level. Therefore, the request for Lumbar Epidural Steroid Injection is denied.

**PER 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).
- (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)