
INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

IRO REVIEWER REPORT TEMPLATE – HC

[Date notice sent to all parties]:

11/5/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L4 transforaminal epidural steroid injections with epidurals with epidurography radiology and anesthesia

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

Board Certified Anesthesiologist
Board Certified Pain Medicine

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient developed complaints of low back pain and ultimately underwent laminectomy foraminotomy and discectomy at L4-5 and L5-S1 bilaterally on 06/16/00. The patient was followed for

post-operative chronic low back pain and utilized Vicoprofen occasionally two to three times per day. The patient was also prescribed Lidoderm patches for the low back. The patient was seen on 11/04/13 for ongoing complaints of low back pain. Physical examination noted intact sensation in the upper extremities and lower extremities with no evidence of motor weakness. Straight leg raise testing caused low back pain only. The patient ambulated with antalgic gait. The patient was felt to have developed facet pain at L3-4 above the level of lumbar fusion from L4 through S1. Facet joint injections at L3-4 were recommended however it was unclear if they were ever performed. The patient was seen for follow up on 01/22/14 with complaints of low back pain radiating to the bilateral thighs. Physical examination noted positive straight leg raise to the left at 40 degrees with full range of motion of the thoracic spine and lumbar spine. No motor weakness was apparent and reflexes were 2+ and symmetric. Sensation was decreased in left L3 through L5 distribution. The report then noted a decreased left patellar reflex at 1+ versus the right side. The patient was recommended for left sided epidural steroid injection transforaminally at L4-5. The updated clinical record a follow up clinical record on 03/20/14 recommended transforaminal epidural steroid injections to the left at L4-5 and L5-S1. The most recent evaluation from 08/11/14 noted ongoing complaints of low back pain that was severe despite medications. Physical examination noted full range of motion of thoracic spine and lumbar spine. No motor weakness was apparent in the lower extremities. There continued to be loss of sensation in L3 through L5 distribution to the left with decreased left patellar reflex. The patient was recommended for guided transforaminal epidural steroid injections at L4. The requested lumbar epidural steroid injections at L4 were denied on 08/13/14 as there were no updated imaging studies showing evidence of nerve root impingement bilaterally at L4 to support the proposed procedures. There was also no indication for anesthesia for the procedures. The request was again denied on 08/19/14 as there was no updated imaging studies or electrodiagnostic studies to confirm evidence of nerve root involvement or radiculopathy and lack of right sided findings to support bilateral epidural steroid injections.

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

The patient has been followed for complaints of chronic low back and radicular pain stemming from previous discectomy and lumbar fusion procedures from L4 through S1. No updated imaging studies were available for review identifying any particular nerve root involvement bilaterally at L4 that would support epidural steroid injections based on guideline recommendations. No other diagnostic testing including EMG was available for review confirming evidence of L4 bilateral radiculopathy. The patient does not have any right sided findings or symptoms per the most records to support bilateral procedures. There is also no indication from the clinical record indicating any procedural anxiety or needle phobia that would support anesthesia services for this procedure. Given that the clinical documentation submitted for review does not meet guideline recommendations for epidural steroid injections or anesthesia services it is the opinion of this reviewer that medical necessity is not established at this time and prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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 (due to herniated nucleus pulposus, but not spinal stenosis) 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.)