

**IRO NOTICE OF DECISION – WC**



Notice of Independent Review Decision

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**Date notice sent to all parties:** July 28, 2014

**IRO CASE #:**

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

Lumbar Epidural Steroid Injection CPT: 64483, 72275, 62311, 77003

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

American Board of Orthopaedic Surgery

**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.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

xxxxx X-rays of the lumbar spine show no fracture or dislocation seen. There appears to be some narrowing of the L5-S1 disc space with slightly focal depression of the superior endplate of L5 vertebral body.

xxxxx MRI of the lumbar spine shows no acute osseous lesion. Desiccation of the L4-L5 disc associated with shallow, central disc herniation which slightly effaces the thecal sac and does not compromise the neural foramina. Desiccation of the L5-S1 disc associated with shallow, central disc herniation which slightly indents the thecal sac and there is no compromise of the neural foramina.

12-4-13, performed a diagnostic interpretation of the MRI of the lumbar spine. He noted that the lumbar spine shows multilevel disc herniations as a direct result of the work injury.

1-14-14, performed a Doctor Selected by Treating Doctor Evaluation. He certified the claimant had reached MMI on this date and awarded the claimant 5% impairment rating based on DRE II.

4-23-14, the claimant complains of pain and swelling in both sides of the lower back. On exam, the claimant has normal motor strength, sensation and reflexes in both the upper and lower extremities. He has tenderness to palpation at the thoracic spine and lumbar spine. He has minimal restricted range of motion at the lumbar spine. The evaluator recommended lumbar epidural steroid injection as he has not improved with extensive conservative treatment.

4-23-14, preoperative orders, pending approval.

4-29-14, performed a UR. Medical necessity for a lumbar epidural steroid injection has not been established, as guideline criteria are not met. ODG does not support epidural injections in the absence of objective radiculopathy. In addition, ODG criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology, and conservative treatment. There are no focal neurological deficits on clinical examination, no imaging evidence of anatomical nerve impingement, and no electrodiagnostic testing to confirm radiculopathy. Without clinical and objective evidence of radiculopathy, the request is not substantiated. Recommend non-certification.

5-7-14, the claimant is not sufficiently improved with conservative treatment. His back pain is 4/10. His low back pain radiates down the right leg along with numbness and tingling. The evaluator recommended a lumbar epidural steroid injection.

5-15-14, UR. He noted the request for a lumbar epidural steroid injection is non-certified. The patient has complaints of bilateral low back pain with associated numbness and tingling in the right lower extremity. An epidural steroid injection is indicated for patients with imaging studies confirming evidence of neurocompressive findings and the clinical exam has revealed findings of radiculopathy. The MRI

showed no confirmation of nerve root compression. There is an indication the patient has complaints of numbness in the right lower extremity; however, the specific distribution of this complaint was not evident. No other radiculopathy was identified. Given these findings, this request is not indicated.

6-30-14, the claimant is not sufficiently improved with physical therapy and he is still symptomatic. On exam, motor strength, sensation and reflexes are normal in the upper and lower extremities. The claimant is filing an IRO for the lumbar epidural steroid injection.

7-8-14 Notice to Claims Eval case of assignment.

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

Medical records reflect a claimant with complaints of pain and swelling in both sides of the lower back. There is a request for a lumbar epidural steroid injection. Per ODG, in order to perform an epidural steroid injection, radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. notes reflect that on exam, motor strength, sensation and reflexes are normal in the upper and lower extremities. The claimant does not have objective documentation of radiculopathy. Therefore, the request for lumbar epidural steroid injection is not established as reasonable or medically necessary.

**ODG 2014 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.)

**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)**