

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: June 22, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection under fluoroscopy with IV sedation level L4-5

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.

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx.

On August 14, 2012, MRI Lumbar Spine, Impression: 1. At L4-5 there is a posterior disc protrusion, likely a disc herniation and ligament flavum hypertrophy, which produce mild central spinal stenosis but no evidence of neural impingement. 2. Mild disc bulge at L3-4.

On September 23, 2012, Operative Report, Postoperative Diagnosis: Lumbar stenosis, left-sided lumbar radiculopathy. Procedure: Left L4-5 transforaminal epidural steroid injection under fluoroscopic guidance.

On November 8, 2013, the claimant presented with pain in her lower back. On physical exam of the spine by palpation, there was moderate pain and discomfort at occiput C7 and T1-T8 bilaterally, a severe degree of pain at L1-L5 and the ilium bilaterally. A slight degree of swelling at L1-L5 and the ilium bilaterally was found on palpation of the spine. Evaluation of the musculature revealed a slight degree of hypertonicity of the suboccipital muscles and upper thoracic muscles bilaterally, a moderate amount of tightness of the lumbar paraspinal muscles bilaterally. There was severe intensity of tenderness at the L5. Soft tissue palpation indicates a moderate amount of muscle tightness of the soft tissue. There was also severe tenderness at the soft tissue. Muscle testing was 3/5 in the lower extremities bilaterally. Lower extremity reflexes were 4/5 bilaterally. Straight Leg Raise was positive on the left. Sensory exam was normal.

On Decembers 12, 2013, the claimant presented for chronic headaches, aching pain at the base of her neck and radiating into the occiput several times a week. Her main complaint was low back pain radiating down the length of her left leg. According to the claimant, she had ESI 4 times, last done in March. The initial two reportedly helped substantially for a few weeks, but the last two did not do much of anything. She also had bilateral sacroiliac joint injections done, but they did not help at all. She was participating in a work hardening program that she was referred to by a surgeon who recommended going through this otherwise she faced a lumbar fusion. She was currently taking Hydrocodone 10 mg 6 times a day. On physical examination she had normal gait and posture. Examination of the lumbar spine revealed decreased flexion on extension as well as side bending. There was a spasm of the quadrates lumborum musculature on the left hand side and tenderness overlying the lumbar facets. There was 4+/5 strength in the musculature on the left hand side when compared to the right. Deep tendon reflexes were intact. There was a slight decrease sensation in the L5 distribution all the way down into the ankle. Assessment: 1. Cervicogenic headaches. 2. Lumbar disk herniation with L5 radiculopathy. Plan: Prescribe Naprosyn, Zanaflex and Gabapentin. also recommended an L5 selective nerve root block.

On January 9, 2014, the claimant presented for follow-up and refill of her medications. She reported that the Neurontin was helping with the pain from her back radiating into her legs as well as helping with headaches. The Naprosyn seemed to be helping as well. She was also taking Zanaflex on a regular basis. Despite the improvements with medication, she reported she was continuing to use 6 Hydrocodone per day.

On April 3, 2014, the claimant presented for follow-up with complaints of pain radiating down the length of both legs, mainly on the left side. She described the pain and tingling was all the way down into the foot. An ESI at L4-5 was recommended.

On April 11, 2014, UR. Rationale for Denial: The ODG supports the use of epidural steroid injections for the treatment of radiculopathy. Based on the clinical documentation provided, the claimant has subjective complaints of radiculopathy,

but no objective evidence of neural impingement is provided. As above, I spoke with the requesting physician, who reported the claimant has had no formal physical therapy, but only a work hardening program for several weeks. As such, in accordance with the ODG guideline criteria, given there are no physical findings of radiculopathy, only subjective complaints, the requested procedure would not be considered medically necessary, reasonable, or appropriate at this time. Therefore, this request is recommended for non-certification.

On April 29, 2014, UR. Rationale for Denial: It was reported that the patient has been active in a work hardening program. There were no work hardening notes provided for review that would indicate the amount of work hardening visits that the patient has completed to date or the patient's response to previous conservative treatment. The Official Disability Guidelines state that the patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). It was reported that the patient has had previous lumbar epidural steroid injections; however, there was no information provided that indicates the patient's response and duration of relief from previous injections. The Official Disability Guidelines state that in the therapeutic phase, after the initial block/clocks are given and found to produce pain relief of at least 50-70% for at least 6-8 weeks, additional blocks may be supported. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. Given this, the appeal request for lumbar epidural steroid injection at L4-5 under fluoroscopy with IV sedation is not indicated as medically necessary.

On May 29, 2014, the claimant presented for follow-up who reported the claimant was prescribed work hardening by her previous physician and according to the claimant, completed at least 10 sessions which were not effective to relieve her pain. She also reported that she had a previous ESI which substantially decreased her pain over 50% which lasted approximately 6 weeks. She continues with severe low back pain with pain radiating down her left leg. Spinal fusion had been recommended but denied. was recommending a lumbar epidural steroid injection at L4-5 as a means to settle her pain back down.

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

Denial of L4-5 ESI is upheld/agreed upon since there is no documented objective findings of radiculopathy; there is no neural impingement noted on imaging studies; there is question regarding compliance with Home Exercise Program as part of more recent efforts of conservative care; there is considerable discrepancy regarding benefits of past ESI's with reports of duration of only 2 weeks and no decrease in medications use (with continued Hydrocodone use) and questionable improvement in function and no reports of return to work. Therefore, the request for Lumbar epidural steroid injection under fluoroscopy with IV sedation level L4-5 is not found to be medically necessary at this time.

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 (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)**