

# CASEREVIEW

**8017 Sitka Street  
Fort Worth, TX 76137  
Phone: 817-226-6328  
Fax: 817-612-6558**

Notice of Independent Review Decision

[Date notice sent to all parties]: May 5, 2014

**IRO CASE #:**

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

ESI L5-S1 Left

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

This physician is Board Certified in Orthopedic Surgery with over 13 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:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who was injured on xx/xx/xx when she slipped on ice and fell backwards. She sustained injuries to her low back and left wrist.

On, the claimant presented with complaints about her arm and low back. On evaluation she had negative bilateral leg raise. Reflexes were symmetrical. Normal gait and normal sensation. She was positive for tenderness with palpation of the spinous process and sacrum and coccyx area. Also positive for tenderness of the paraspinal muscles. She had pain with side bending and rotation. X-rays of the lumbar spine revealed no fracture. Assessment: 1. Contusion of the lumbar region. 2. Contusion sacrum and coccyx. 3. Wrist contusion. Plan: Apply ice to area 10 minute duration for 4-5 times a day. Prescription: Mobic 7.5 mg.

On December 18, 2013, the claimant presented to PT for an initial physical therapy evaluation. PT 3 x wk for 2 wks was recommended.

On January 2, 2014, the claimant presented for continued pain in the lower back that radiates to the left thigh sometimes. She has completed 6 sessions of PT. On evaluation she had a normal gait and no palpable spasms. There was tenderness of the coccyx, sacrum and paraspinal muscles. ROM was painful with flexion and extension. Plan: Continue work restrictions, Mobic and request more PT.

On March 6, 2014, MRI of the Lumbar Spine, Impression: 1. Mild narrowing and dehydration in the L4-5 disk. A 2.4 mm central disk protrusion compresses the thecal sac and produces canal narrowing. 2. Dehydration with narrowing and slight disk bulge or spur at L5-S1. Canal narrowing is present. 3. Right foraminal narrowing at L4-5. 4. Bilateral facet arthropathy at L4-5 and L5-S1. 5. No acute compression fracture present.

On March 19, 2014, the claimant presented with low back and buttock pain. She reported some numbness or heavy feeling to her buttocks bilaterally. She denied having any pain radiating down the leg or tingling. She has managed her pain with Celebrex and Flexeril, however those medication do make her sleepy. She completed 10 sessions of physical therapy which she reported as not helpful. She has had no chiropractic treatment, back injection or back surgery. On evaluation her gait was stable and she was able to walk and balance on heels and toes. There was no tenderness to palpation of the coccyx. There was tenderness to palpation of the lumbar spine at L4-5, tenderness to the lumbar paravertebral musculature bilaterally as well as muscle spasm, bilateral SI joint pain to palpation. Negative straight leg raising bilaterally. On the right, lower extremity strength was 5/5, except EHL was 4-5/5. Lower extremity strength on the left was 5/5. Neurologically intact to light touch in bilateral lower extremities. No pain with flexion, but there was pain with extension, left-sided rotation and right-sided lateral bending. X-rays of the lumbar spine showed a slight bit of rotation and curve to the left, decreased joint space at the hips bilaterally, iliac crest slightly higher on the right side as well as the hips. There was disc space narrowing at L5-S1 and to a lesser degree L4-5, no spondylolisthesis decreased at the L5-S1 facet, possible arthrosis. Plan: Continue with physical therapy and an ESI injection at L5-S1 level.

On March 26, 2014, performed a UR. Rationale for Denial: Regarding epidural steroid injection at left L5-S1, Genex CGT indicates epidural steroid injection for acute or recurrent radicular pain (e.g., sciatica) when improvement is not seen following a minimum of three weeks of conservative treatments (e.g., physical therapy, exercise, medication). In this case, it is noted that the claimant has persistent pain in the low back and buttock region despite prior physical therapy sessions. Submitted documentation indicates that the claimant has clinical deficits on examination which include tenderness at L4-L5 region and lumbar paravertebral musculature, muscle spasm of bilateral sacroiliac joint, and

weakness of the right extensor hallucis longus. The recommendation of the provider is epidural steroid injection at left L5-S1. Although the claimant has central disc protrusion, right foraminal narrowing, and disc space narrowing at L5-S1, there are no clear deficits or neurological impairment directed to the left L5-S1 to warrant the requested injection. Without correlation of findings from objective deficits and diagnostic imaging, the medical necessity for the requested epidural steroid injection at left L5-S1 is established. Recommend non-certification.

On April 4, 2014, a UR. Rationale for Denial: Regarding lumbar epidural steroid injection, a prior denial of the requested intervention on 03/26/14 is noted. Prior report notes that there are no clear deficits or neurological impairment directed to the left L5-S1 to warrant the requested injection. Guidelines note that epidural steroid injection is indicated for patients with unequivocal evidence of radiculopathy must be documented before therapeutic injections are considered an option. Peer discussion notes that the claimant has radicular pain to the buttocks and that the claimant has failed conservative approaches. The "sidedness" of the request is not that important and the ESI is meant for the entire lower lumbar area, consistent with the claimant's MRI findings. The claimant has right side EHL weakness, tenderness to palpation at L4-5, and MRI findings that show stenosis and degeneration. The intention is to attempt to alleviate the claimant's pain which has not responded to any measure to date. However, there is insufficient evidence of radicular pain as well as neurological deficits such as motor or sensory changes in the dermatomal distribution of right L5-S1 level that necessitate lumbar epidural steroid injection. Thus, medical necessity for the proposed intervention is not established. Non-certification is recommended.

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

The requested epidural injection is not indicated in this claimant. An epidural steroid injection (ESI) reduces pain and inflammation in the setting of radiculopathy associated with a disc herniation. The Official Disability Guidelines (ODG) supports ESI when objective findings are consistent with radiculopathy and confirmed by imaging studies and/or electrodiagnostic testing.

This claimant does not have clear evidence of radiculopathy. On March 19, 2014, she reported buttock pain, but no pain radiating down her leg. She had a negative straight leg raise sign. She had weakness in her right EHL. No sensory deficits were identified. This evaluation is not fully consistent with lumbar radiculopathy. An EMG/nerve conduction study would be required to confirm the radiculopathy prior to consideration of an ESI. Therefore, the proposed ESI L5-S1 Left is not medically necessary.

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)**