



**MEDICAL EVALUATORS  
OF TEXAS ASO, LLC.**

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**Notice of Independent Review Decision**

**DATE OF REVIEW: May 1, 2014**

**IRO CASE #:**

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

*3<sup>rd</sup> bilateral L5-S1 transforaminal ESI*

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

This case was reviewed by a physician who holds a board certification in Anesthesiology with sub-specialty in a Pain Medicine. The reviewer is currently licensed and practicing in the State of Texas.

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This is a male who sustained injury to his lower back on xx/xx/xx. Mechanism of injury is unknown. He had MRI of the lumbar spine on 08/21/2013 that showed, "the postoperative alignment of the lumbar spine is anatomic. No segmental instability is noted. No acute fracture is seen. At L4-5 an annular disc bulge flattens the thecal sac. At L5-S1 a solid anterior interbody fusion with placement of an interbody spacer is seen. Anterior as well as posterolateral fixation bilateral pedicle screws at L5 are noted. The left pedicle screw encroaches upon the left lateral recess of L5 as well as the left L5 nerve root as seen on transaxial images #24 and #25. Facet joint arthrosis is noted. There is flattening of the thecal sac with narrowing of the left neuroforamen." Records review indicates that he had bilateral L4-L5 TF ESI on 11/06/2013 with 50% pain relief and second ESI on 12/18/2013. He was seen for a followup evaluation with chief complaint of lower back pain radiating to bilateral lower extremities. His pain level was at 8/10. On physical exam of lumbar spine,



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ROM was decreased, strength and tone was diminished due to pain. On extremities exam, there was no atrophy, sensations were intact throughout, no spasticity, no gait abnormality, no limp, tone was normal, no waddling. He was recommended 3<sup>rd</sup> bilateral L4-5 and L5-S1 TF ESI.

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

ODG criteria for low back and lumbar and thoracic epidural injections define radiculopathy as, “objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.” Based on progress note dated 02/28/2014, which is the only progress note available, the patient presented with symptoms of bilateral leg pain. An EMG/NCV performed on 09/14/2013 showed left L5-S1 radiculopathy. These are good documentations supporting radiculopathy.

**However, there were no documentations of radiculopathy on physical exam.** There was no straight leg raising performed and no documentations of motor or sensory deficit. In fact, sensory exam of the legs were normal and gait was normal.

After 2 ESIs, the patient is in therapeutic phase. ODG states “repeat injections should be based on **continued objective documented pain relief, decreased need to pain medications, and functional response.**” The progress note on 02/28/2014 do not state as such.

Using the above ODG criteria, the adverse determination for the third TF ESI is upheld.

**ODG – Low Back – Lumbar & Thoracic (Acute and Chronic)**

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



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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.)



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**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
- X** 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)