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Notice of Independent Review Decision

December 19, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
1 Lumbar Transforaminal Epidural Steroid Injection at the Left L4-L5 between 11/17/2014 and 1/6/2015

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Anesthesiologist with over 6 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned (Disagree)

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]:

09/09/2014: MRI of the Lumbar Spine without contrast. **Findings:** L1-L2: No evidence of this herniation, stenosis, or nerve root compromise. L2-L3: No evidence of disc herniation, stenosis, or nerve root compromise. L3-L4: Left paracentral 5 mm disc herniation is present with partial superior extrusion flattening the thecal sac and proximal left L4 nerve root. L4-L5: Broad-based annular bulge and mild facet Arthropathy is present without significant stenosis or nerve root compromise. L5-S1: Mild disc space narrowing is present with a left paracentral and left lateral, foraminal, 3-4 mm disc protrusion/herniation with facet Arthropathy creating effacement of the thecal sac with left L5 nerve root and foraminal encroachment. Marrow signal throughout this lumbar vertebral bodies is preserved. Conus meduliaris is normal at T12-L1. **Impression:** Left sided disc herniations at L3-L4 and L5-S1.

10/07/2014: Procedure Note. **Postop Diagnosis:** Lumbar Displacement: ICD9-722.10, Lumbar Neuritis/Radiculitis: ICD9=724.4, Backache NOS: ICD9-724.5 **Procedure:** Epidurogram/Neurogram, Fluoro Guidance/Localization of Needle or Catheter. **Plan:** Follow up 2 weeks.

10/08/2014: Office Visit. **Chief Complaint:** is a male who presents to the office for treatment. This patient is here for management of his low back symptoms. He contributes his current symptoms to work injury. Patient describes his symptoms as follows. Achy, sharp. He reports not having any new injuries since his last visit. He has stated his pain level is a 5/10. had his injection performed on October 7, 2014. **ROM:** Patient has 75% of normal lumbar ROM. **Tissue/Muscle Tightness:** Patient has abnormal tissue/muscle hypertonicity in the bilateral lumbar erector spine. **Plan:** I request 3 visits of PT, which is in compliance with ODG guidelines. Follow up in 1 week.

11/06/2014: Follow Up Visit. **Subjective:** is here today for a follow up visit. He is post lumbar epidural steroid injection 10/7/14 with some significant improvement post injection. He comes in today rating his pain as 6/10 VAS. He complains of bilateral shoulder pain, low back pain, and muscle spasms. He reports left lower extremity intermittent pain, numbness, and tingling mainly in the L4 and L5 dermatomal left which has decreased post injections and is now intermittent. His left patellar and Achilles reflexes are slightly sluggish as compared to the right. There is decreased sensory mainly in the L4-L5 dermatome via light touch has improved post injection. He reports coughing and sneezing increases his low back pain. MRI of the lumbar spine dated 9/9/14 revealed a 5 mm disc herniation at L3-L4 with partial superior extrusion flattening the thecal sac and proximal left L4 nerve root, a disc bulge at L4-L5 with mild facet Arthropathy, a 3-4 mm disc herniation/protrusion at L5-S1 with facet Arthropathy creating effacement of the thecal sac with left L5 nerve root and foraminal encroachment. He currently takes Robaxin 750 mg tid as a muscle relaxant and tramadol 50mg bid tid for pain control. He has been able to reduce his pain medication post injection. His ROM to the lumbar spine has increased and has been able to increase his activity. We will request a second lumbar epidural steroid injection since he made significant improvements in his first injection. I would like him to continue with home therapy as directed and to use his TENS unit as needed. We will see him back in the office in approximately 4 weeks or 2 weeks post procedure. **Plan:** Follow up 4 weeks.

11/12/2014: UR. The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The patient is a male who reported injury on xx/xx/xx. The mechanism of injury was not provided. His diagnoses include lumbar displacement, muscle spasm, shoulder joint pain, lumbar neuritis/radulitis, and backache. His current medications were noted to include tramadol HCI 50 mg 3 times daily as needed and Robaxin 750 mg 3 times daily. Surgical history was noted to include translaminar ESI of the lumbar spine and epidurogram/neurogram performed on 10/7/14. His diagnostic studies included an official MRI of the lumbar spine performed on 9/9/14, which indicated left sided disc herniations at L3-4 and L5-S1. His other therapies were noted to

include home therapy, TENS unit, and epidural steroid injections. On the clinical note dated 11/6/14, the patient complained of bilateral shoulder pain, low back pain, and muscle spasms rated 6/10. Medical records indicated the patient received lumbar epidural steroid injection on 10/7/14 with some significant improvement post injection. Upon examination, the patient had decreased sensory mainly in the L4-5 dermatome via light touch, which was noted to have improved post injection. The patient reports coughing and sneezing to increase his low back pain. ROM and muscle strength was noted to be mildly decreased. The patient is noted to have positive straight leg raise test on the left. The treatment plan was for 1 lumbar transforaminal epidural steroid injection at the left L4-5. The ODG recommend epidural steroid injections as an option for treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and electro diagnostic testing. The patient must be initially unresponsive to conservative treatment. Injections should be performed using fluoroscopy for guidance. A second block is not recommended if there is inadequate response to the first block. No more than 2 nerve root levels should be injected using transforaminal blocks and fused levels should not be injected. In the functional improvement, including at least 50% pain relief for 6 to 8 weeks, with reduction of medications. The patient has documentation of radiculopathy on physical exam and corroborated by imaging. However, there is a lack of documentation indicating the efficacy of the previous ESI to have provided at least 50% pain relief with reduction of medication for 6 to 8 weeks. As such, the request for 1 lumbar transforaminal epidural steroid injection of the left L4-5 is non-certified.

11/25/2014: Letter of Reconsideration. This letter is in regard to my request for a 2nd transforaminal epidural steroid injection. She had significant pain relief from the 1st injection, greater than 70%. This does meet ODG criteria for a 2nd injection.

12/03/2014: UR. This is an appeal of a left L4-L5 transforaminal epidural steroid injection that was previously non-certified. The claimant is a male who was injured on xx/xx/xx. The claimant was diagnosed with displacement of the lumbar intervertebral disc without myelopathy. An MRI of the lumbar spine on September 9, 2014, documented a left-sided disc herniation at L3-L4 and L5-S1. The L3-L4 disc herniation was 5mm with partial superior extrusion flattening the thecal sac and proximal left L4 nerve root. At L5-S1there was mild disc space narrowing with a left paracentral and left neural foraminal 3-4 mm disc protrusion/herniation with facet Arthropathy which created effacement of the thecal sac with left L5 nerve root and foraminal encroachment. A translaminar epidural steroid injection at l4-L5 was performed on October 7, 2014. An evaluation on November 6, 2014 documented significant improvement after the epidural steroid injection. Complaints of bilateral shoulder pain, low back pain, and muscle spasms were reported. There was left lower extremity intermittent pain, numbness, and tingling which was mainly in the L4-L5 dermatome which was decreased after the injection. Decreased sensation, mainly in the L4-L5 dermatome, was noted to have improved after the injection. Coughing and sneezing increased the low back pain. No current medications were reported. Previously the claimant had been taking Robaxin and tramadol. There was mild lumbar spinal tenderness and

paraspinal tenderness which was greater on the left. There was left sided buttock tenderness. Mildly decreased ROM was noted. Deep tendon reflexes were symmetric. Sensation was mildly decreased in the left lower extremity and there was mildly decreased motor strength. Diminished ankle reflex was noted on the left with positive straight leg raise testing was documented. A letter of reconsideration on November 25, 2014 documented the pain relief after the first injection was greater than 70%. This is a non-certification of an appeal of the left L4-L5 transforaminal epidural steroid injection. The previous non-certification was due to a lack of documentation the previous injection provided greater than 50% pain relief for six to eight weeks. The previous non-certification is supported. Additional records include a letter of reconsideration. ODG-Treatment in Worker's Compensation indicates there must be 50-70% pain relief for six to eight weeks. The letter of reconsideration indicated there was 70% pain relief however there was no indication of the length of the relief. The follow-up evaluation was four weeks after the first injection. The guidelines state repeat injections are supported when there is objective evidence of significant pain relief including a decreased need for pain medication and improved functional response which was not documented in the records. The request for an appeal of a left L4-L5 transforaminal epidural steroid injection is not certified.

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

The previous adverse determinations are overturned. Claimant was diagnosed with displacement of the lumbar intervertebral disc without myelopathy. Claimant had an ESI with greater than 70% pain relief at the follow-up evaluation that was four weeks after the first injection. The guidelines state repeat injections are supported when there is objective evidence of significant pain relief including a decreased need for pain medication and improved functional response. Claimant had documented radiculopathy, had a successful ESI with greater than 70% of pain relief for several weeks. Therefore, the request for 1 Lumbar Transforaminal Epidural Steroid Injection at the Left L4-L5 between 11/17/2014 and 1/6/2015 is medically necessary at this time and is certified.

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)**