

CASEREVIEW

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[Date notice sent to all parties]: June 28, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection at L3-L4, L4-L5, L5-S1 with Fluoroscopic Guidance 62311x3 77003

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

This physician is Board Certified in Anesthesiology with over 6 years of experience, including experience in Pain Management.

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx when she fell after hitting her left foot on a palette. She fell on her left side on the palette and her right side onto concrete. She was initially treated with medication and 6 sessions of physical therapy for the lumbar spine.

On August 18, 2014, X-ray of the Lumbar Spine, Impression: 1. No radiographic evidence of acute fracture or subluxation of the lumbar spine. 2. Mild-to-moderate degenerative change of lumbar spine at L4-5 and L5-S1 levels.

On September 22, 2014, MRI of the Lumbar Spine, Impression: 1. 3mm right L1-2 central/dorsal lateral disc protrusion with small annular tear mildly narrows the right L1-2 lateral recess but no central canal stenosis is observed. 2. There is multilevel spondylosis and disc bulging, but no significant canal stenosis at L2-3, L4-5, L5-S1 are seen. Spinal canal at L3-4 is borderline stenotic due to dorsal osteophytes and disc bulging. 3. Multilevel neural foraminal encroachment.

On October 17, 2014, the claimant presented with neck and low back pain. She complained of constant neck pain rated a 6/10 with no radiation into the upper extremities. Her low back pain was described as constant at a level 10 with radiation, left greater than right leg. She also complained of numbness and tingling in both legs and feet. On examination of her lumbar spine the range of motion was limited in flexion, extension and lateral tilting. To palpation there was evidence of tenderness and spasm. No motor or sensory problems were reported. Diagnoses: 1. Displacement of lumbar intervertebral disc without myelopathy. 2. Cervicalgia. 3. Lumbar pain. 4. Brachial Neuritis or Radiculitis. Medications included Tramadol Hcl 50 mg. Plan: MRI of the cervical spine and physical therapy for the cervical spine 2 x 4 weeks.

On December 17, 2014, the claimant presented with continued low back pain that was described as constant and rated 5-10/10 with radiation in the legs, right greater than left. She also complained of numbness in both legs with weakness in both legs. On physical examination there was no atrophy. Muscle groups tested in the upper and lower extremities were a grade 5. Deep tendon reflexes were normoactive. Sensory examination was normal in the upper and lower extremities. Range of motion of the lumbar spine were limited in flexion, extension and lateral tilting. Sacroiliac joint were not painful. There was tenderness and spasm to palpation. Tiptoe and heel walking were well done. Straight leg rising did reproduce radiculopathy. Anaprox 275 mg was prescribed and she was continued on Tramadol HCL 50 mg. Plan: LESI L3-4, I4-5 and L5-S1 and CESI C4-5 and C3-4.

On January 28, 2015, the claimant presented with continued neck, low back and right shoulder pain. She reported some abnormalities on her liver enzymes, therefore she discontinued the Anaprox. She reported her pain significantly increased after stopping. There were no changes in physical exam reported. Current medication: Tramadol HCL 50 mg.

On April 29, 2015, the claimant presented with continued low back pain that radiates into her left leg. On physical examination there was no atrophy. Muscle groups tested in the upper and lower extremities were a grade 5. Deep tendon reflexes were normoactive. Sensory examination was normal in the upper and lower extremities. Range of motion of the lumbar spine was not limited in flexion, extension and lateral tilting. Sacroiliac joint were not painful. There was no tenderness and spasm to palpation. Tiptoe and heel walking were well done. Straight leg rising did not reproduce radiculopathy. Plan: LESI L3-4, L4-5, L5-S1.

On May 8, 2015, UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There were physical examination findings that did not suggest radiculopathy. The guidelines do not support no more than two nerve root levels injected.

On May 26, 2015, UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines

referenced above, this request is non-certified. There were no sensory, motor or reflex deficits and root tension signs were negative.

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

Based on the records submitted, using the evidence-based, peer-reviewed guidelines referenced below, this request is non-certified. Physical examination did not suggest radiculopathy. Per ODG, injection at more than two nerve root levels is not supported. Therefore, this request for Lumbar Epidural Steroid Injection at L3-L4, L4-L5, L5-S1 with Fluoroscopic Guidance 62311x3 77003 is non-certified.

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, muscle relaxants & neuropathic drugs).
- (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)**