

ReviewTex. Inc.
1818 Mountjoy Drive
San Antonio, TX 78232
(phone) 210-598-9381 (fax) 210-598-9382
reviewtex@hotmail.com

Date notice sent to all parties:

May 11, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Epidural steroid injection – Lumbar 64483 64484 77003

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

Board Certified Anesthesiology

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 patient is a male who was injured on xx/xx/xx while pulling. The patient indicated that he developed low back pain and was initially assessed with a sprain/strain injury. The patient was referred for physical therapy and given anti-inflammatories. MRI of the lumbar spine from 12/23/14 noted disc protrusion at L5-S1 with facet hypertrophy severely narrowing the left lateral recess with left S1 nerve root impingement. There was slight contact of the descending right S1 nerve root. The patient reported persistent low back pain radiating to the left lower extremity in an L5-S1 distribution despite physical therapy chiropractic treatment medicate and medications. The patient was referred for an epidural steroid injection. The patient underwent the first epidural steroid injection to the left at S1 on 03/10/15. The post injection follow up on 03/25/15 noted the patient had relief from the epidural steroid injection for only a half of a day. The patient was

recommended to repeat epidural steroid injection on the 03/25/15 clinical record. Physical examination at this visit noted antalgic gait with decreased sensation to light touch in the left lower extremity in non-specified distribution. The repeat epidural steroid injection with guide with fluoroscopy was denied by utilization review on 03/25/15 as there was lack of clinical documentation of appropriate response to the first epidural steroid injection based on pain relief and duration to support repeat epidural steroid injections. The request was again denied on 04/03/15 as there was again limited evidence regarding the efficacy of the first epidural steroid injection to support repeat injections.

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

The patient has been followed for persistent complaints of a left S1 radiculopathy that failed initial conservative treatment including therapy and medications. The patient was recommended for epidural steroid injection which was done in March of 2015 to the left at S1. Per the records the patient only received half day relief from the epidural steroid injection. Per guidelines patients are recommended to have at least 50-70% relief radicular symptoms with epidural steroid injections for a six to eight week period. As this was not achieved with the first epidural steroid injection, guidelines would not support proceeding with a second epidural steroid injection. The most recent physical examination findings were unremarkable for any clear evidence of an active S1 radiculopathy to the left. Therefore it is the opinion of this reviewer that medical necessity for the proposed second epidural steroid injection with fluoroscopy has not been established based on guideline recommendations.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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.)