INDEPENDENT REVIEWERS OF TEXAS, INC.

2150 S. Central Expressway · Suite 200-264 · McKinney, Texas 75070
Office 214-533-2864 Fax 214-380-5015
e-mail: independentreviewers@hotmail.com

[Date notice sent to all parties]:

06/03/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar ESI under fluoroscopy w/ IV sedation right L4-L5.

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:

☐ x 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 an individual. On 09/03/14, an MRI of the lumbar spine revealed 2mm bulges at L3-4 and L4-5 flattening the thecal sac without causing central canal stenosis. The bulges and disc narrowing caused mild bilateral foraminal stenosis at the respective levels. There was no lumbar compression fractures noted and no central stenosis was seen in lumbar spine. On 09/08/14, the patient was seen in clinic for evaluation of lumbar sprain and right knee meniscal injury. Pain was rated at 9/10 at that time. On 11/21/14, the patient was seen for initial pain evaluation for persistent and chronic back right buttock and right leg pain with associated numbness weakness and tingling as well as right knee pain. On exam, the patient had decreased pin prick sensation in an L5 distribution across the lateral right thigh going into the anterior tibial region with mild weakness of the EHL on the right as compared to left. On 01/13/15, the patient was taken surgery for a pre-operative diagnosis of chronic back syndrome and L4-5 lumbar disc protrusion

with right lumbar radiculopathy, and he underwent a lumbar epidural steroid injection under local anesthetic using fluoroscopy. On 01/15/15, the patient returned to clinic and noted complete resolution of his right buttock and leg pain complaints after the single lumbar epidural steroid injection but he still reported 20-30% pain in his low back area. His muscle spasms had responded and resolved with ice therapy. He wanted to proceed with a second block building upon the benefit to help resolve the remainder of his pain complaints. On 03/11/15, the patient returned to clinic, and it was noted the first injection provided 70% improvement of pain and improved function. It was noted he was able to decrease medications usage until he was approved for a second injection. On 05/06/15, the patient was seen in clinic for continued complaints of chronic low back pain with lumbar radiculopathy. It was noted the patient had 70% improvement of pain and increased activity at home with exercising at home and daily walking. He still reported moderate lumbar interspinous tenderness with pain in the right sided notch area.

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

On 04/06/15, a utilization review report was submitted for the requested lumbar epidural steroid injection under fluoroscopy with IV sedation, right L4-5, and it was noted that the carrier was disputing compensability of the 2mm bulges at L3-4 and L4-5 that flatten the thecal sac without causing central stenosis, and the bulges and disc narrowing causing mild bilateral foraminal stenosis at their respective levels, as these conditions were not caused or aggravated by the compensable injury.

On 05/04/15, a utilization review reconsideration report was submitted noting the request for a appeal for right L4-5 injection was not certified due to lack of response to the previous injection. While it was noted that the patient reported 70% pain relief with a return of symptoms two months after the previous injection, it was noted the records were unclear as to whether the 70% pain relief had lasted the entire two months after that first injection. It was also reported there was no documentation of decreased pain medication usage or increased function after the previous injection.

The records indicate the patient has had one epidural steroid injection that was performed on 01/13/15. That injection was given under fluoroscopic guidance with the use of a local anesthetic block. When the patient was seen on 01/15/15, he ported complete resolution of his right buttock and leg pain complaints falling that injection. He still reported 20-30% low back pain. When he was seen on 03/11/15, patient reported more than 70% improvement of pain with improved function following the first injection. He was sleeping and exercising. He reported being able to cut his medications down until he was approved for a second injection. The guidelines indicate that not only should radiculopathy be documented by physical examination and corroborated by imaging studies or electrodiagnostic studies, in a therapeutic phase, repeat blocks should be based on continued objective

documented pain and functional improvement including at least 50% pain relief with associated reduction of medication use for six to eight weeks. While it is noted the patient had complete resolution of his radicular pain with the first block, the records do not indicate the patient has radiculopathy on exam as it was reported his radicular symptoms were completely resolved with the first block. Additionally, guidelines do not support IV sedation for this type of injection due to the risk of potential diagnostic and safety issues.
Therefore it is opinion of this reviewer that the request for lumbar epidural steroid injection under fluoroscopy with IV sedation right L4-5 is not medically necessary and prior denials are upheld.

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

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

☐ **x ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Sedation: There is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. This is of particular concern in the cervical region. (Hodges 1999) Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. The general agent recommended is a benzodiazepine. (Trentman 2008) (Kim 2007) (Cuccuzzella 2006) While sedation is not recommended for facet injections (especially with opioids) because it may alter the anesthetic diagnostic response, sedation is not generally necessary for an ESI but is not contraindicated. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. Supervision services provided by the operating physician are considered part of the surgical service provided.

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, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

1) Radiculopathy must be documented by physical examination and 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) for guidance.

4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)

8) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.

9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.