

# Medical Assessments, Inc.

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## IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Transformational Lumbar Epidural Steroid Injection @ Right L5 and S1

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

The Reviewer is Board Certified in the area of Anesthesiology with over 6 years of experience, including 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 male that was picking up a XX when he felt a pain in his low back while at work on XX/XX/XX.

XX/XX/XX: MRI L spine W/O contrast. 1. Disc pathology and facet hypertrophy at L3-L4 and L4-L5 involving the nerve roots within the lateral recesses. 2. Involvement of the neural foramina at L5-S1.

XX/XX/XX: Office visit. Claimant reports the pain is in the low back and radiates to the right buttock. He experiences intermittent pain down the posterior aspect of the leg to the knee with occasional tingling in both feet. The claimant states the pain is a 5/10. He describes it deep and pins and needles. The pain is worsened with standing and bending. The pain is improved with sitting and lying down. **Previous treatment:** 4 months of PT without any benefit. He underwent a lumbar laminectomy at L3/4 on the right back in XX/XXXX but he has continued to have persistent pain. He's tried various NSAID's for pain control and states that he "dislikes pain medications". **Plan:** will proceed with transformational ESI at L5, S1. **Examination:** Reveals normal strength, equal deep tendon reflexes, and there is diminished sensation in the left L4 and S1 dermatomes. There is tenderness to palpation of the spinous process at L4-L5 and a positive right straight leg raise test. There is pain with lumbar flexion. The claimant has a diagnosis of lumbar intervertebral disc without myelopathy and post-laminectomy syndrome.

XX/XX/XX: UR. The claimant is a male, status post injury XX/XX/XX. Subjective findings of pain over the low back radiating to right buttock and posterior aspect of the leg occasional tingling over the bilateral feet. Diagnoses of back pain with radiation, displacement of thoracic or lumbar intervertebral disc without myelopathy, and post-

laminectomy syndrome of the lumbar region. Treatment to date of PT, activity modification, and medications. Therefore, certification of the requested Transformational Lumbar Epidural Steroid inj R L5/S1 is not recommended.

XX/XX/XX: UR. The claimant is a male who reportedly was injured on XX/XX/XX. The claimant was picking up a XX when he had pain in his low back. The failed PT appears to be from care performed prior to the lumbar surgery in XX. The documentation provided is an initial evaluation report. There is no support for failed conservative care to address the current complaints resulting in a request for a right L5/S1 ESI in XX/XXXX. Without an initial failure of conservative care, invasive care, this is not supported. Denial of this request is recommended.

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

The previous determination has been upheld. Claimant is a XX-year-old male who was injured on XX/XX/XX. Claimant was picking up XX when he had pain in his low back. The failed PT appears to be from care performed prior to the lumbar surgery in XXXX. Subjective findings of pain over the low back radiating to right buttock and posterior aspect of the leg occasional tingling over the bilateral feet. Diagnoses of back pain with radiation, displacement of thoracic or lumbar intervertebral disc without myelopathy, and post-laminectomy syndrome of the lumbar region. The documentation provided is an initial evaluation report. There is no support for failed conservative care to address the current complaints resulting in a request for a right L5/S1 ESI in XX/XXXX. Without documentation of failure of conservative care this request is non-certified. Therefore, the request for Transformational Lumbar Epidural Steroid Injection @ Right L5 and S1 is non-certified.

#### **ODG 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.)

**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)