Date notice sent to all parties: 1/17/2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of transforaminal lumbar epidural steroid injection at left L3-L4 with fluoroscopy and intravenous sedation as an outpatient.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in Anesthesiology.

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

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of transforaminal lumbar epidural steroid injection at left L3-L4 with fluoroscopy and intravenous sedation as an outpatient.

PATIENT CLINICAL HISTORY [SUMMARY]:
Patient is a XX year old XX with history of lower back injury. CT of the lumbar spine from XXXX demonstrated mild findings of spondylosis at T12-L1 L1-L2 and L2-L3. These findings mildly narrow the central spinal canal at L2-L3. There was anterior bulging of the disc with anterior osteophyte formation at the L3-L4. There was mild posterior bulging of the disc and there was a symmetrical broad-based disc protrusion along the central left posterior lateral disc margin of moderate size. This produces a left anterior extradural defect on the thecal sac. It affects origin of the L5 nerve root. There was mild to moderate L3 foraminal stenosis present on both sides with crowding of the exiting root sheath of the neural foramen on both sides. The patient was status post laminectomy, anterior fusion and posterior fusion at the L4-L5. There was no significant acquired central spinal canal stenosis. The L4 foramen was slightly narrow down the sides related to mild posterior lateral bone hypertrophy. There was mild degenerative joint disease involving the cingulate joint on both sides. On physical examination dated XXXX, patient complained of low back pain. The pain was described as burning, dull and tingling. The pain was an 8/10. The patient complained of back pain with radiation into the anterior thighs with associated numbness and tingling. On examination, there was diminish sensation to touch to the bilateral anterior thighs and medial and lateral aspect of the bilateral lower legs along L4 and L5 nerve distribution. Patient had a positive straight leg raise on the right at 40° with pain in the right anterior thigh along the L3 dermatome. Patient had positive straight leg raise on the left at 40° with

left anterior thigh pain along the L3 distribution. The patient had 5-/5 hip flexion, knee flexion and extension as well as dorsiflexion and plantarflexion. The patient had 4+/5 hip flexion on the right.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Per evidence-based guidelines, and the records submitted, this request is non-certified. Per ODG, epidural steroid injections are recommended if there's evidence of radiculopathy that is corroborated by imaging findings. There needs to be evidence that the patient has completed conservative treatment. Excessive sedation should be avoided. The use of sedation during epidural steroid injection remains controversial and is indicated for anxiety. Documentation provided for review to get the patient positive straight leg raise bilaterally in the L3 distribution. The patient had decreased strength on hip flexion bilaterally. The patient had diminished sensation in the L3 L4 and L5 nerve distribution. However, other than a letter, there was no documentation the patient had significant anxiety to want the requested sedation. As such, the request for transforaminal lumbar epidural steroid injection at the left L3 L4 with fluoroscopy and intravenous sedations is not medically necessary.

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition: Chapter: Low Back- Lumbar and Thoracic:
Epidural steroid injections, diagnostic
Recommended as indicated below. Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed as a diagnostic technique to determine the level of radicular pain. In studies evaluating the predictive value of selective nerve root blocks, only 5 percent of appropriate patients did not receive relief of pain with injections. No more than 2 levels of blocks should be performed on one day. The response to the local anesthetic is considered an important finding in determining nerve root pathology. (CMS, 2004) (Benzon, 2005)
When used as a diagnostic technique a small volume of local is used (Epidural steroid injections (ESIs), therapeutic

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 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. Infections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
4. Diagnostic Phase: At the time of the initial use of an ESI (formally referred to 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.
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 on 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 percent 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 "series of three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.
10. It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
11. Cervical and lumbar steroid injection should not be performed on the same day;
12. Additional criteria based on evidence of risk:
a. ESIs are not recommended higher than the C6-C7 level;
b. Cervical interlaminar ESI is not recommended; &
c. Particulate steroids should not be used. (Benzon, 2015)

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)**