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July 17, 2018
IRO CASE #: XXXX
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
ESI Rt L5 S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This case was reviewed by a Board Certified Doctor of Anesthesiology with experience in Pain Management with over 12 years of experience.

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]:

XX: EMG/NCS Consultation Left Lower Extremity by XX, MD. **HPI:** XX year old right handed employee of XX who was injured on the job on XX. XX continues to work despite XX problems. XX has had evaluation up to date including MRI of the lumbar spine on XX. It does describe left L4-5 and L5-S1 disc protrusions. XX has had no previous electrodiagnostic studies. XX has had a single transforaminal LESI which provided XX some benefit. XX continues with 5/10 severity pain which worsens the longer XX is up on XX feet at work. 100% pain into the left buttock and leg and down into the lateral calf and dorsum of the foot. XX has had no surgeries to the lumbar spine. **Summary:** 1. Left L5 radiculopathy with denervation and reinnervation. 2. Mild left superficial peroneal sensory neuropathy at the ankle. 3. No evidence to suggest peripheral neuropathy. **Recommendations:** 1. XX is to follow up with XX regarding the results of today's study. 2. XX is tentatively scheduled for an LESI next week. 3. Consideration might be given toward updated MRI imaging if the LESI does not provide adequate benefit for XX, per XX s consideration.

XX: Electrodiagnostic Results by XX, MD. **Conclusions:** Left L5 radiculopathy w/ denervation/reenervation mild left superficial peroneal sensory neuropathy at ankle. No evidence to suggest periph neuropathy.

XX: MRI L-Spine w/o contrast interpreted by XX, MD. **Impression:** 1. Disc dessication with far left lateral protrusion at L4-L5 extending into the inferior aspect of the neural foramina on the left at L4-L5. This may contact the exiting left L4 root. 2. Moderate sized right paracentral disc protrusion at L5-S1 deflects the right S1 root posteriorly.

XX: Operative Report by XX, MD. **Preoperative diagnosis:** 1. Left L4-5 herniated nucleaus pulposus. 2. Right L5-S1 herniated nucleus pulposus. **Operation:** 1. Left far lateral L4-5 microdiskectomy. 2. Right L5-S1 hemilaminotomy and microdiskectomy.

XX: Operative Report by XX, MD. **Preoperative Diagnosis:** right L5 S1 recurrent disc herniation with nerve compression. **Operation:** Right L5 S1 discectomy and decompression.

XX: Follow up by XX, PA. **HPI:** Patient presents today reporting XX has had increased pain over the last couple months. Pain radiates from XX right low back approximately L5/S1 down the posterior buttock and thigh to just behind XX knee. XX also has some numbness and tingling to XX toes and feet. XX denies focal weakness to XX legs but with prolonged standing at times XX leg may try to give way. XX remains functional and denies new injury or inciting event. XX states XX has not responded well to the past ESI. XX has not had an MRI in years. XX has had some good response to PT in the past, which is an option. XX pain is worse with prolonged standing. Better with pain meds and wearing XX back brace when XX is more active. **Assessment/Plan:** Refill XX 10/325. Schedule XX for lumbar spine MRI. XX will make further recommendations at that time.

XX: MRI L-Spine w/o contrast interpreted by XX, MD. **Impression:** 1. Previous disc protrusion at L5-S1 to the right has been resected. There is right hemilaminotomy and postoperative changes around the right S1 root. Mild residual posterior spurring and narrowing of the inferior aspect of both L5-S1 foramina. 2. L4-5 reveals broad based disc protrusion, mild narrowing of the inferior aspect of the left L4-L5 foramen. This appears to be unchanged from the previous study in XX. 3. L3-L4 reveals facet artrosis causing only minimal thecal sac effacement. This is stable from XX.

XX: Office Visit by XX, MD. **HPI:** Patient is a pleasant XX. We have been seeing XX for many years for pain related to a lumbar disk herniation that resulted in permanent nerve root damage. This lumbar radiculopathy is improving by EMG and XX receives 100 pain pills every 90 days, and this has lasted perfectly. XX just ran out yesterday. XX has noticed a modest increase in pain, and so we got an updated MRI. **Plan:** XX brought in updated lab work, showing normal kidney function and normal liver function. XX would like to schedule a lumbar transforaminal injection. That will be on the right at L5 and S1.

XX: UR performed by XX DO. **Rationale for Denial:** The requested right L5 select ESI is not medically necessary. The neurological exam by the requesting surgeon in XX was devoid of any radicular findings, so there is no support for a transforaminal ESI based on that. The MRI showed pathology at the right S1 nerve root, not the L5 nerve root, so there is no support for a right L5 injection. Finally, XX note contained no exam details, so this does not support any injection at any level.

XX: UR performed by XX, MD. **Rationale for Denial:** Right L5 select ESI was non-authorized per appeal. The requested right L5 select ESI is not medically necessary. In this case, the injured worker has complaints of back pain with some radiation into the lower extremity. The provider is requesting an ESI. The documentation does not substantiate a recent trial and failure of comprehensive conservative care, including physical therapy. There was no objective documentation of failure of conservative treatment measures specifically addressed to the lumbar spine to support the need for the requested procedure, as actual PT reports were not submitted for review. The request for a right L5 select ESI is not medically necessary at this time.

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

Based on the records submitted and peer-reviewed guidelines, this request is non-certified. In this case, the injured worker has complaints of back pain with some radiation into the lower extremity. The provider is requesting an ESI. The documentation does not substantiate a recent trial and failure of comprehensive conservative care, including physical therapy. There was no objective documentation of failure of conservative treatment measures specifically addressed to the lumbar spine to support the need for the requested procedure, as actual PT reports were not submitted for review. Therefore, this request for a right L5 select ESI 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, the reduction of medication use and the avoidance of 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, XXs, muscle relaxants, and 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.)

(12) Excessive sedation should be avoided.

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)**