CASEREVIEW
8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

March 30, 2018, Amended June 21, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Therapeutic Lumbar Epidural Steroid Injection Bilateral L5/S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified in Anesthesiology and has over 10 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 XXXX who was injured on XXXX while XXXX. XXXX reported that XXXX. Following the injury XXXX developed radiculopathy L4-5 and L5-S1 which was treated conservatively with physical therapy and medication. MRI was eventually ordered and XXXX was assessed by a spinal surgeon who recommended surgery. This was denied and a second surgeon also recommended surgery, but again surgery was denied. In XXXX determined that the patient had a previous sold fusion at L4-5, but a failed attempt of fusion at L5-S1 and that there was a disc herniation and spinal stenosis at L3-4 above the fusion. XXXX recommended fusion at L3-4 and L5-S1, but again surgery was denied. XXXX has undergone ESI treatment.

On XXXX, the claimant presented to XXXX for low back pain that radiates into both lower extremities. On physical examination toe and heel walking was poor. Deep tendon reflexes were diminished in the lower extremities. Straight leg raise positive bilaterally. Sensory deficit in the bilateral L5/S1 dermatome noted.

On XXXX, the claimant presented to XXXX for Caudal Epidural Steroid Injection.

On XXXX, the claimant presented to XXXX one month following ESI. XXXX reported improvement in overall pain by more than a half and was able to stand longer, sit longer, walk longer, sleep better, decreased pain medicine and had less stress.

On XXXX, the claimant presented to XXXX for Caudal Epidural Steroid Injection.

On XXXX, the claimant presented to XXXX one month following 2nd ESI. XXXX reported improvement in overall pain by more than a half and was able to stand longer, sit longer, walk longer, sleep better, and decreased pain medicine. No change in physical examination.

On XXXX, the claimant presented to XXXX with continued low back pain that radiates into both lower extremities. XXXX is able to stand, sit and walk for more than 30 minutes. Pain level now 4-6/10. XXXX reported medication and injections have helped. After the last ESIs XXXX had improvement in pain by more than 50%. XXXX was able to stand, sit and walk longer. XXXX was able to decrease pain medication. Duration of 50% relief was for greater than 2 months. Plan is for additional ESI. The claimant is noted to have a degree of anxiety about needles.

On XXXX, XXXX performed a UR. Rationale for Denial: Guidelines indicate regarding epidural injections, radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Per this review, there is no evidence of nerve root impingement at L5-S1 on MRI. Furthermore, the request includes a CPT code for monitored anesthesia care. Although sedation is indicated in cases of anxiety, the expertise of an anesthesiologist or anesthetist is seldom if ever indicated for sedation for lumbar epidural steroid injections. Per ODG, the least amount of sedation for the shortest duration of effect is recommended. In this case, there is no note of severe neurological or psychiatric comorbidities that might indicate a need for MAC for this procedure. As such, the requested therapeutic lumbar epidural steroid injection at bilateral L5 and/or S1 is not medically necessary and is non-certified.

On XXXX, XXXX performed a UR. Rationale for Denial: There is no documentation provided indicating a reduction in pain medication or objective evidence of improvement in function. Moreover, there was no MRI report provided to corroborate the findings of radiculopathy in this patient. Therefore, the request for APPEAL Therapeutic Lumbar Epidural Steroid Injection Bilateral L5/S1 is non-certified.

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

Based on records submitted and peer reviewed guidelines, this request is non-certified. There is no specific documentation provided indicating the amount of reduction in pain medication or objective evidence of improvement in function. Although it is reported that XXXX can sit, stand and walk longer, there are no specific indications of how much longer. Moreover, there was no MRI report provided to corroborate the findings of radiculopathy in this patient. There is also no recent physical examination provided. Therefore, the request for Therapeutic Lumbar Epidural Steroid Injection Bilateral L5/S1 is not found to be medically necessary at this time.

PER ODG:

XX

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)**