CASEREVIEW
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March 5, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left L5 and S1 Transforaminal Epidural Steroid Injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician specializes in Physical Medicine and Rehabilitation with over 20 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]:
The claimant is a XXXX who was injured on XXXX when a XXXX and hit XXXX on the lower side of XXXX neck and low back. XXXX developed some low back pain wand was seen at XXXX in XXXX. XXXX had 6-7 sessions of therapy but was not improving. Following a MRI, XXXX was referred to XXXX, orthopedic spin specialist. XXXX recommended a trial of injections.

On XXXX, MRI Lumbar Spine Impression: 1. Broad-based posterior disk protrusion as described at L5-S1 level causing mild to moderate spinal canal narrowing and effacement of the lateral recesses on both sides, worse on left. There is indentation of the S1 nerve roots particularly on the left side. 2. Central to left paracentral slight inferiorly extruded disk herniation at L4-L5 level causing mild spinal canal narrowing with slight effacement of right lateral recess.

On XXXX, the claimant presented to XXXX who recommended a Pain Management referral. Noted: ESI left L5S1 was recommended by spinal surgeon, XXXX.

On XXXX, the claimant presented to XXXX with pain in XXXX low back that radiated down the entire left lower extremity. XXXX had numbness and tingling around the ankle itself. XXXX had tightness in XXXX calf. XXXX rated XXXX pain level about an 8. Current Medications: Lodine, Ultram, and Tylenol ES. On examination XXXX had a non-tender lumbosacral spine. XXXX was tender to left paraspinals and over the left sacral sulcus. No muscle spasms or trigger points noted. There was slight decrease in movement of the left sacral sulcus as compared to the right. Negative Gillette test. Motor

was 5/5 bilateral lower extremities. Sensation subjectively reported some tingling in the left leg. Reflexes were symmetrical 1 to 2+ patella bilaterally. 1+ Achilles on the right. 0 Achilles on the left. Gait was slightly antalgic and slow paced. XXXX was able to do toe raises. Negative straight leg raises in the sitting position to 90 degrees. Assessment: Lumbosacral sprain/strain. Disc protrusions and herniations at L4-L5 and L5-S1. Rule out left lower extremity S1 radiculopathy. Recommendations: Recommend lumbar epidural steroid injection and to continue current medications.

On XXXX, the claimant presented to XXXX with pain combination of 50% low back and 50% left leg, posterior calf, outside lateral thigh. XXXX rated the pain an 8. On examination, left PF 4+/5, left ankle jerk was 0. Plan: left L5 and S1 TF lumbar epidural steroid injection.

On XXXX, operative report, Postoperative Diagnosis: 1. Traumatic, work-related lumbar sprain and strain. 2. Traumatic, work-related lumbar disk displacement. Procedure Performed: Fluoroscopically guided, contrast enhanced left L5-S1 and left S1 transforaminal epidural steroid injections with epidurograms.

On XXXX, the claimant presented to XXXX for ESI follow-up. XXXX reported XXXX had gotten 55% relief from XXXX pain. Medications included tramadol oral and Tylenol Extra Strength oral. Plan: Trail of physical therapy, 1-3 visit to train on a home exercise program of lumbar stabilization, neutral bias with posterior pelvic tilts, hamstring stretching and abdominal exercises. Continue pain medication as prescribed. If symptoms recur, repeat ESI.

On XXXX, the claimant presented to XXXX with continued back and left leg pain following ESI and some physical therapy. XXXX reported the ESI only gave XXXX some improvement for about two weeks and then XXXX had recurrent problems. His assistant, a licensed occupational therapist, gave some instructions in a home exercise program. XXXX would reevaluate in two weeks.

On XXXX, the claimant presented to XXXX with continued pain rated around a 7. XXXX reported home exercises were not helping and XXXX was interested in possibly trying a repeat injection. Recommendation: repeat injection with an aggressive therapy program and mini-TPE.

On XXXX, the claimant presented to XXXX with some discomfort in the same dermatomal pattern, but with some improvement. XXXX reflexes were now present in both ankles, although the left side remained diminished compared to the right. XXXX was encouraged to bump XXXX exercise program up to 45 minutes of walking twice a day and was told XXXX could take XXXX Tramadol a little more often if necessary in order to comply with the exercise program. Return in one month.

On XXXX, XXXX performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The objective findings documented showed no significant changes to validate the efficacy of the previous injection given. There was no change in medication use and no documented change in return to work status or clear objective measures of functional improvement. Given the lack of clinical indication, the request for left L5 and S1 transforaminal epidural steroid injection is not warranted as medically necessary.

On XXXX, XXXX performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, repeat injections should be based on continued objective documented pain relief, decreased the need for pain medications, and functional response. XXXX stated that transforaminal epidural steroid injection had 55 percent relief of pain. However, there was no

documentation that the patient had a decreased need for pain medications. There was also no documentation that injection was adjunct to active rehab efforts as treatment alone offers no significant long-term functional benefit. Thus, the request is not supported.

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

Determination: Denial of left L5 and S1 transforaminal ESI is UPHELD/AGREED UPON given that despite reported initial response of 55% relief in pain with previous Left L5 and S1 ESI, that relief only lasted 2 weeks and there was no objective reduction in reported pain scale thereafter, no reported decreased use of analgesic medication, and no reported improvement in function.

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, NSAIDs, 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)**