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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar epidural steroid injection (ESI)

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

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

X Overturned (Disagree)

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 patient is a XXXX who was injured on XXXX. The patient was XXXX and felt a pop in XXXX lower back. XXXX had an immediate onset of pain that began radiating down XXXX left leg.

On XXXX, the patient underwent a physical therapy (PT) evaluation at XXXX. XXXX had difficulty bending over, standing on XXXX left leg, lifting objects. Leaning forward, and to XXXX side increased the pain. XXXX had difficulty lying down on XXXX left side. XXXX reported a history of the previous injury to XXXX lower back when XXXX was XXXX. The current pain level was 4/10 in the lower back. PT three times a week for four weeks was recommended.

On XXXX, XXXX, evaluated the patient at XXXX. The patient reported continued lower back pain radiating down the left leg. The pain level was 8/10. XXXX past medical history was positive for diabetes mellitus. On exam, the range of motion (ROM) was decreased in all planes. The muscle spasms along the paraspinal muscles remained the same. The tenderness remained the same. Sitting and supine straight leg raising (SLR) was negative bilaterally. X-rays of the lumbar spine dated XXXX, was negative for fracture or dislocation. XXXX diagnosed sprain of the ligaments of the lumbar spine and prescribed Mobic, Robaxin and Medrol Dosepak and recommended continuing therapy. Light duty restrictions were recommended.

From XXXX, Through XXXX, the patient attended several PT sessions at XXXX. The modalities included manual therapy, therapeutic exercises, therapeutic activities, neuromuscular re-education and home exercise program (HEP).

On XXXX, the patient underwent a magnetic resonance imaging (MRI) of the lumbar spine at XXXX, which was interpreted by XXXX. The indication for the study was lower back pain radiating to the left lower extremity. The study revealed a posterior disc protrusion measuring approximately 4 mm at L4-L5 with minimal right lateralization creating minimal right foraminal stenosis and encroachment upon the right L4 nerve roots. There was a posterior disc protrusion measuring 3.3 mm at L5-S1 contacting the thecal sac without stenosis. There was minimal right foraminal stenosis identified at the level L3-L4. There was an incidental 3 mm cyst along the posterior margins of the right L3-L4 facet joint.

On XXXX, XXXX re-evaluated the patient in a follow-up visit. The patient reported radiation of lumbar, left hip and leg pain to the left knee. The pain level was 7/10. XXXX recently had an MRI and had presented to discuss the report. XXXX continued PT and prescribed Lodine and Flexeril. Because of the bulging disc and foraminal stenosis, XXXX recommended an ESI.

On XXXX, XXXX noted that the patient's symptoms overall remained the same. The exam now showed positive sitting SLR on the left. XXXX noted the HEP was not helpful. Lodine and Flexeril were prescribed. ESI was awaited. Restricted duty was continued.

On XXXX, XXXX, evaluated the patient at XXXX. The patient reported low back pain radiating into the left lower extremity. XXXX was able to stand for less than 30 minutes, sit for less than 30 minutes, and walk for less than 30 minutes. The current pain level was 4-6/10. The pain had been going on for several months. The examination was notable for poor heel walking on the left. The deep tendon reflexes (DTR) were diminished in the lower extremities. The SLR was positive on the left. There was a sensory deficit in the left L4-L5 dermatome. XXXX diagnosed sprain of ligaments of the lumbar spine and recommended diagnostic ESI.

On XXXX, a preauthorization request for a diagnostic lumbar ESI at L4-L5 on the left was submitted.

On XXXX, XXXX refilled Lodine and Flexeril and awaited the ESI approval.

On XXXX, XXXX., completed a utilization review and denied the request for a diagnostic lumbar epidural injection at left L4-L5 with sedation. Rationale: *"The history and documentation do not objectively support the request for an ESI at level L4-L5 on the left side at this time. The ODG state ESI may be recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Criteria for the use of Epidural steroid injections: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). There is no clear objective evidence of radiculopathy on the left side and the injured worker's complaints and findings are on the right side, including physical findings and MRI results. The MRI report does not indicate the presence of nerve root compression at the level to be injected. The medical necessity of this request has not been clearly demonstrated and a clarification was not obtained."*

A correspondence dated XXXX, notified XXXX about the denial.

On XXXX, XXXX re-evaluated the patient at XXXX. The patient continued to have low back pain. There were no significant changes on the exam. XXXX planned to appeal the denial.

On XXXX, XXXX noted the patient reported a pain level of 7/10. XXXX overall symptoms remained the same. XXXX continued to prescribe Lodine and Flexeril and restricted duty.

On XXXX, a preauthorization request for diagnostic lumbar ESI at L4-L5 on the left x1 was submitted by XXXX office.

On XXXX, XXXX, completed a reconsideration and upheld the denial. Rationale use for the denial was as follows: *"The request for Diagnostic Lumbar Epidural Injection left L4-5 with sedation is not medically necessary. In this case, the injured worker has complaints of back pain radiating into left lower extremity, along with deficits in the left L4-5 dermatome. MRI of the lumbar spine demonstrates right-sided nerve root impingement. There is no corroborating nerve root impingement on the MRI. As such, medical necessity of this request is not established."*

In a letter dated XXXX, the carrier notified the denial to XXXX.

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

Epidural Steroid Injections are:
Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition. In fact, according to SPORT, ESIs are associated with less improvement in spinal stenosis. (Radcliff, 2013) Short-term symptoms: The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. (Armon, 2007) Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function or return to work. There is no high-level evidence to support the use of epidural injections of steroids, local anesthetics, and/or opioids as a treatment for acute low back pain without radiculopathy. (Benzon, 1986)

ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. (Kinkade, 2007) Epidural steroid injections are an option for short-term pain relief of persistent radiculopathy, although not for nonspecific low back pain or spinal stenosis. (Chou, 2008) As noted above, injections are recommended if they can facilitate a return to functionality (via activity & exercise). If post-injection physical therapy visits are required for instruction in these active self-performed exercise programs, these visits should be included within the overall recommendations under Physical therapy, or at least not require more than 2 additional visits to reinforce the home exercise program.

An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal-Cochrane, 2009) Recent studies document a 629% increase in expenditures for ESIs, without demonstrated improvements in patient outcomes or disability rates. (Deyo, 2009) There is fair evidence that epidural steroid injection is moderately effective for short-term (but not long-term) symptom relief. (Chou3, 2009) This RCT concluded that caudal epidural injections containing steroids demonstrated better and faster efficacy than placebo. (Sayegh, 2009) ESIs are more often successful in patients without significant compression of the nerve root and, therefore, in whom an inflammatory basis for radicular pain is most likely. In such patients, a success rate of 75% renders ESI an attractive

temporary alternative to surgery, but in patients with significant compression of the nerve root, the likelihood of benefiting from ESI is low (26%). This success rate may be no more than that of a placebo effect, and surgery may be a more appropriate consideration.

When used for diagnostic purposes the following Procedure Summary – Low Back Procedure/topic Summary of medical evidence indications have been recommended:
1)To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below: 2) To help to evaluate a radicular pain generator when physical signs and symptoms differ from that found on imaging studies; 3) To help to determine pain generators when there is evidence of multi-level nerve root compression; 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive; 5) To help to identify the origin of pain in patients who have had previous spinal surgery.

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.

The patient suffered an injury with documented radiculopathy with a positive left SLR, decreased sensation to pin prick in the L45 dermatome and non-responsive to conservative care. The previous denials were based on lack of corroborative findings on MRI and radiculopathy. The Official Disability Guidelines (ODG) do provide for this type of injury and account for it in the ESI section as indicated above: "in whom an inflammatory basis for radicular pain is most likely." Furthermore, utilizing the "When used for diagnostic purposes section" for ESI, as listed above, the patient in fact does meet the criteria for a diagnostic ESI. Therefore, according to the ODG, the request for a Left L4 ESI is certified with IV sedation for anxiety. Please note that further requests for ESI must meet the Therapeutic phase criteria.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

X PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)