# CASEREVIEW

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May 5, 2018
**IRO CASE #:** XXXXXX

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
Lumbar Epidural Steroid Injection at Left L5/S1 with Anesthesia

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
This physician is a Board Certified Anesthesiologist with 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 patient is a XX who was injured on XXXX while XX. XX was XX left knee and leg. The pain went all the way up to the lower back. XX does have a history of lower back pain from an injury XX. MRI from XXXX showed: 1. Posterior and rightward disc herniation measuring approximately 6 mm at L5/S1 is creating moderate right lateral recess and right foraminal stenosis. 2. Rightward disc herniation measuring approximately 5mm at L2/3 with resulting mild to moderate right foraminal stenosis and mild impingement upon the right L2 nerve roots. 3. Moderate bilateral foraminal stenosis at L4/5 secondary to broad-based posterior disc herniation measuring approximately 5mm. 4. Broad-based posterior disc herniation measuring approximately 5 mm at L3/4 with subtle left lateralization creating mild to moderate bilateral foraminal stenosis, left greater than right. The claimant received physical therapy, work conditioning and work hardening for XX left knee. Physical therapy for XX lower back was denied initially but approved in XXXX.

On XXXX, the claimant presented to XX for physical therapy visit XX. XX reported back pain of 4/10. XX is able to performed activities of daily living independently, but cannot perform recreational activities independently. Diagnosis: Lumbar strain with radiculopathy. Therapy Assessment: Overall Progress: As expected. Increase pain with bridging. May need to address ADIM/PPT next visit. Continue therapy per treatment plan.

On XXXX, the claimant presented to XX for low back pain that radiates into the left lower extremity. Exam: No significant changes in the physical exam since the last office visit. Assessment: Sprain of ligaments of lumbar spine. Procedure in Office: Lumbar Epidural Steroid Injection.

On XXXX, the claimant presented to XX for follow-up after the ESI. Claimant reported 50% improvement in XX pain. XX reported being able to stand, walk, and sit longer, but still had pain at bedtime and wakes up in pain.

Exam: Otherwise unchanged. Plan: Left Lumbar ESI. Physical therapy after the injection. Discontinue XX.

On XXXX, XX performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request is non-certified. Guidelines recommend ESI's fro short-term treatment of radicular pain in conjunction with active rehab efforts. There must be documented radiculopathy including objective signs and corroborated by imaging studies and/or electrodiagnostic testing and pain initially unresponsive to conservative therapy (exercises, physical methods, NSAIDs, muscle relaxants, and neuropathic drugs.) A repeat ESI should be based on objective pain relief, reduction in medication use, and improved function. A repeat ESI is not indicated if there is inadequate response to the first block (<30% relief). In patients with initial pain relief of 50-70% for 6-8 weeks and an acute exacerbation of pain or new onset of radicular pain, a repeat ESI is an option. The patient in question had a lumbar ESI in XXXX with 50% pain relief. However, there was no documentation of the duration of the pain relief nor was there objective documentation of reduced medication use after the epidural. There is documentation of planned physical therapy after the injection. Post-procedure medical records provide no subjective or objective documentation of radicular pain to indicate the patient is having an acute exacerbation. Physical exam findings state "unchanged" which is insufficient to indicate the patient is currently having an acute exacerbation of radicular pain. There is also no documentation of failed conservative therapy. Therefore, the request for 1 Lumbar Epidural Steroid Injection at Left L5/S1 with Anesthesia is not medically necessary and is non-certified.

On XXXX, XX performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request is not certified. In light of this presenting issues and in the absence of pertinent extenuating circumstances that would require deviation from the guidelines, the appeal request for 1 Lumbar Epidural Steroid Injection at Left L5/S1 with Anesthesia between XXXX and XXXX is not medically necessary as there is insufficient documentation of continued objective documented pain relief, a decreased in the need for pain medications, and functional response from prior injection to warrant this request.

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

The previous adverse determinations are upheld. Based on ODG criteria, there must be documented radiculopathy including objective signs and corroborated by imaging studies and/or electrodiagnostic testing and pain initially unresponsive to conservative therapy (exercises, physical methods, NSAIDs, muscle relaxants, and neuropathic drugs.) A repeat ESI should be based on objective pain relief, reduction in medication use, and improved function. A repeat ESI is not indicated if there is inadequate response to the first block (<30% relief). In patients with initial pain relief of 50-70% for 6-8 weeks and an acute exacerbation of pain or new onset of radicular pain, a repeat ESI is an option. The patient in question had a lumbar ESI in XXXX with 50% pain relief. However, there was no documentation of the duration of the pain relief nor was there objective documentation of reduced medication use after the epidural. Additionally, there is no documentation of planned physical therapy after the injection. There is also no documentation of failed conservative therapy. Therefore, the request for 1 Lumbar Epidural Steroid Injection at Left L5/S1 with anesthesia is not medically necessary and 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, 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)**