Medical Assessments, Inc.

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IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient lumbar transforaminal epidural steroid injection at left L3-L4

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

The Reviewer is Board Certified in the area of Anesthesiology 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 claimant is a XX who was injured on XXXX. The claimant was diagnosed with lumbar radiculopathy.

XXXX: Office visit by XX. The claimant complained of lower back pain. The pain was rated 5/10. The claimant developed lumbar pain that would radiate into the left lower extremity to the ankle with numbness, paresthesias and weakness. Although the numbness and paresthesias improved to some degree, the claimant still has constant lumbar pain radiating to the buttock and lower extremity. The pain with in the lower extremity had markedly diminished and the claimants gait had improved. However, the claimant still had moderate left lumbar pain radiating into the buttock and lower extremity weakness. The claimant did have some XX bleeding for XX after the procedure. There was loss of sensation to touch and temperature in the left L3-4 distribution compared to the right. There was less weakness noted within the proximal left lower extremity especially within the quadriceps musculature, which the provider rated as 4/5. Treatment included second left L3-4 ESI.

XXXX: UR performed by XX. Rationale for denial: Although it appears this patient receive some relief with the initial lumbar epidural, the progress notes does not quantify the amount of pain relief. AS such, this request for repeat left L3-4 transforaminal ESI is not appropriate or medically necessary.

XXXX Office visit by XX. Revealed that the claimant was having continued lower back pain that was radiating into the left lower extremity. Current Medications included, gabapentin, which provided added benefit to reported symptoms. The claimant rated pain as 7/10. The PE revealed a positive straight leg raise on the left at 50 degrees with pain shooting into the left lower extremity. There was loss of sensation to touch in temperature and left L3-L4 distribution compared to the right and there was weakness within the proximal left lower extremity. Deep

tendon reflexes were noted to be equal in the lower extremities and dorsiflexion was somewhat diminished in the left lower extremity.

XXXX: UR performed by XX. Rationale for denial: The claimant is a XX who was injured on XXXX. The claimant had a previous ESI to the left L3-4 on XXXX with substantial improvement. There was no diagnostic imagine made available for review to provide objective evidence of nerve root impingement. The request for lumbar transforminal ESI at L2-L4 is non certified.

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. Though the claimant had a previous ESI to the left L3-4 on XXXX with substantial improvement, there was no diagnostic evidence made available for review to provide objective evidence of nerve root impingement. Therefore, this request for lumbar transforminal ESI at L2-L4 is not medically necessary.

ODG Guidelines:

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)**