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An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:
64483: Left S1 transforaminal epidural steroid injection

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified Anesthesiology

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)
XX with who was diagnosed with complex regional pain syndrome I of the left lower limb (G90.522). On XXXX, XX was injured due to XX. The associated diagnoses included pain in the left foot, pain in the left lower leg and pain in the joints of the left foot.

On XXXX, XX was seen by XX for left ankle pain. There was constant nagging and sharp pain for XX. The pain was rated as 6/10. The modifying factors included staying off feet. The associated symptoms included pain. XX fulfilled the Budapest criteria for complex regional pain syndrome (CRPS) in that XX had vasomotor symptoms, motor symptoms and pain of a sharp and stabbing nature.

The treatment to date included medications (nonsteroidal anti-inflammatory drugs and muscle relaxants), physical therapy, lumbar sympathetic block and repair of the left foot ligament. XX had tried XX and XX, which caused significant sedation and XX was unable to tolerate these medications.

An MRI of the lumbar spine performed on XXXX revealed a disc protrusion at LS-S1, abutting the S1 nerve roots with mild foraminal stenosis.

Per an initial utilization review decision letter dated XXXX the requested service was denied by XX. The submitted records did not support the requested epidural steroid injection as reasonable or necessary. An MRI study noted contact of the S1 nerve roots, the physical examination did not identify any correlating findings consistent with an active radiculopathy. There was no other supporting diagnostic evidence of radiculopathy available for the review. It was also unclear what previous conservative measures had been attempted for suspected radiculopathy. Given these issues which did not meet guideline recommendations, the request for left S1 transforaminal steroid injection was non-certified.

Per a reconsideration utilization review decision letter dated XXXX, the requested service of left S1 transforaminal epidural steroid injections was denied by XX. It was determined that the request did not meet medical necessity guidelines. The guidelines indicated that criteria for an epidural steroid injection included documented evidence of radiculopathy on physical examination, which was not clearly identified. Additionally, as noted in the prior denial, there was insufficient documentation regarding prior non-operative treatment modalities. A peer-to-peer discussion with XX was established regarding the above request, who indicated that the epidural was recommended in hopes of avoiding spinal cord stimulator trial. XX had previously been diagnosed with complex regional pain syndrome but a possible discogenic pain generator was found on the MRI. However, as previously noted, there was still a lack of documented radiculopathy on physical examination. Therefore, the left S1 transforaminal steroid injection was non-certified.

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Notice of Independent Review Decision

Case Number: XXXXXX Date of Notice: XXXX

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The prior adverse determination is upheld. Given the documentation available, the requested service(s) is considered not medically necessary.

This patient was diagnosed with Complex Regional Pain Syndrome 1 (CRPS) using the Budapest Criteria. XX has been treated extensively for CRPS which has included lumbar sympathetic blocks and medications, all of which failed. An EMG/NCS detected a left sural neuropathy which can mimic CRPS. A spinal cord stimulator (SCS) trial is now under consideration. A lumbar MRI showed a herniated disc abutting the S1 nerve root.

Both prior reviews correctly questioned the rationale for the requested left S1 transforaminal ESI since there is no electrodiagnostic evidence of a lumbar radiculopathy. The clinical findings also do not support a lumbar radiculopathy. In addition, XX has never received any physical therapy, an important component of the conservative treatment of radiculopathy. While the rationale that an ESI be used to avoid a SCS trial deserves merit, there is no evidence to support this intervention, which is why the prior adverse determination is upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines DWC-Division of Workers
- ☐ Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back
- ☐ Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines

ODG® 2018 Official Disability Guidelines® (23rd annual edition) & ODG® Treatment in Workers' Comp (16th annual edition)
ODG -TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines

Low Back - Lumbar and Thoracic (Acute and Chronic) (updated 12/28/17)
Epidural steroid injections, diagnostic

Recommended in selected cases as indicated below.
Indications for diagnostic epidural steroid injections:
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.

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Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed, in part, as a diagnostic technique to determine the level of radicular pain. The role of these blocks has narrowed with the advent of MRIs. Few studies are available to evaluate diagnostic accuracy or post-surgery outcome based on the procedure and there is no gold standard for diagnosis. No more than 2 levels of blocks should be performed on one day. The response to the local anesthetic is considered an important finding in determining nerve root pathology. (CMS, 2004) (Benzon, 2005) When used as a diagnostic technique a small volume of local is used (<1.0 ml) as greater volumes of injectate may spread to adjacent levels. (Sasso, 2005) (Datta, 2013) (Beynon, 2013)

Epidural steroid injections (ESIs)

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:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

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).

3) Injections should be performed using fluoroscopy (live x-ray) for guidance.

4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)

8) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.

9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.

Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a “series of three” ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. 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. See the Low Back Chapter for more information and references. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral 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, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007)

Sedation: There is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. This is of concern in the cervical region. (Hodges 1999) Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. The general agent recommended is a benzodiazepine. (Trentman 2008) (Kim 2007) (Cuccuzzella 2006) While sedation is not recommended for facet injections (especially with opioids) because it may alter the anesthetic diagnostic response, sedation is not generally necessary for an ESI

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but is not contraindicated. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. Supervision services provided by the operating physician are considered part of the surgical service provided.

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

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