

# P-IRO Inc.

An Independent Review Organization

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**DATE OF REVIEW:** JUNE 26, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar epidural steroid injection with fluoro and trigger point 4-6

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

Board Certified

**REVIEW OUTCOME**

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

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

1. Lumbar epidural steroid injection with fluoro—**IS** medically necessary
2. Trigger point 4-6—**IS NOT** medically necessary

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Nurse review, 05/14/07

Review, Dr., 05/25/07

Lumbar MRI, 05/06/04

Lumbar MRI without contrast, 12/07/06

Office note, Dr., 02/12/07 and 05/08/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male property manager who sustained a low back injury on xx/xx/xx from an unknown mechanism. There is reference to a prior low back injury in xxxx without the details provided. Lumbar MRI evaluation performed on xx/xx/xx noted L5-S1 mild broad based central disc bulge or protrusion abutting bilateral thecal sac and S1 nerve roots with left posterior lateral annular tear and a normal L4-5 disc. The claimant reportedly treated with physical therapy, medications and two epidural steroid injections in January of 2006 with noted improvement. He then sustained re-injury moving furniture later and went for a third epidural steroid injection that failed to offer any benefit.

A repeat MRI from 12/07/06 indicated stable L5-S1 disc when compared to the xx/xx/xx study; mild right lateral recess narrowing at L5-S1; and a mild L4-5 disc bulge mildly effacing the right lateral recess without significant nerve root compression. The claimant is currently a non-smoker and treating with Tramadol and activity modification. Physical examination from 02/12/07 demonstrated normal gait, sensation, motor and reflex findings with reproducible trigger points in the quadratus lumborum, gluteal medius and gluteal maximus. The claimant underwent L4-5 and L5-S1 medial branch blocks in March of 2007 without noted benefit and continued the use of anti-inflammatories. On 05/08/07 the claimant reported continued low back and gluteal pain. Physical examination noted painful range of motion and positive straight leg raises for low back pain only. Recommendations were made for two epidural steroid injections under fluoroscopy, trigger point injections and narcotic analgesia.

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

The lumbar epidural steroid injection is recommended and medically necessary for this claimant. However, trigger point injections are not recommended until the results of the lumbar epidural steroid injection can be evaluated. Per this submitted documentation, it is difficult to understand how benefits of either would be evaluated when they are done simultaneously. The preponderance of the literature would also support the primary procedure which has shown some benefit for this claimant in the past. This would allow evaluation and subsequent recommendation.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back-Epidural Steroid Injections, Fluoroscopy for Epidural Steroid Injections, and Trigger Point Injections.

#### **Epidural Steroid Injections- Lumbar:**

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). 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.

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. 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) (ISIS, 1999) (DePalma, 2005) (Molloy, 2005) (Wilson-MacDonald, 2005)

Use for chronic pain: Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. (Hopwood, 1993) (Cyteval, 2006) Indications for repeating ESIs in patients with chronic pain at a level previously injected (> 24 months) include a symptom-free interval or indication of a new clinical presentation at the level.

Transforaminal approach: Some groups suggest that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. (Riew, 2000) (Vad, 2002) This approach may be particularly helpful in patients with

large disc herniations, foraminal stenosis, and lateral disc herniations. (Colorado, 2001) (ICSI, 2004) (McLain, 2005) (Wilson-MacDonald, 2005)

Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. (Manchikanti, 1999) (Colorado, 2001) (ICSI, 2004) (Molloy, 2005)

Factors that decrease success: Decreased success rates have been found in patients who are unemployed due to pain, who smoke, have had previous back surgery, have pain that is not decreased by medication, and/or evidence of substance abuse, disability or litigation. (Jamison, 1991) (Abram, 1999) Research reporting effectiveness of ESIs in the past has been contradictory, but these discrepancies are felt to have been, in part, secondary to numerous methodological flaws in the early studies, including the lack of imaging and contrast administration. Success rates also may depend on the technical skill of the interventionalist. (Carette, 1997) (Bigos, 1999) (Rozenberg, 1999) (Botwin, 2002) (Manchikanti, 2003) (CMS, 2004) (Delpont, 2004) (Khot, 2004) (Buttermann, 2004) (Buttermann2, 2004) (Samanta, 2004) (Cigna, 2004) (Benzon, 2005) (Dashfield, 2005) (Arden, 2005) (Price, 2005) (Resnick, 2005) (Boswell, 2007) Also see Epidural steroid injections, "series of three" and Epidural steroid injections, diagnostic. ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. (Kinkade, 2007)

### **Criteria for the use of Epidural steroid injections:**

*Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and 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. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. (Andersson, 2000)

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

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

(4) 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 two injections should be performed. A second block is not recommended if there is inadequate response to the first block. 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. To be considered successful after this initial use of a block/blocks there should be documentation of at least 50-70% relief of pain from baseline and evidence of improved function for at least six to eight weeks after delivery.

(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 (the phase after the initial block/blocks were given and found to produce pain relief), repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)

(8) Repeat injections should be based on continued objective documented pain 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 as this may lead to improper diagnosis or unnecessary treatment.

**Fluoroscopy for ESI:**

Recommended. Fluoroscopy is considered important in guiding the needle into the epidural space, as controlled studies have found that medication is misplaced in 13% to 34% of epidural steroid injections that are done without fluoroscopy. See Epidural steroid injections (ESI's).

**Trigger Point Injections:**

Not recommended in the absence of myofascial pain syndrome. See the Pain Chapter for Criteria for the use of Trigger point injections. Trigger point injections involve the injection of local anesthetic into soft tissues (muscles) near localized tender points in the paravertebral area. The theory that such trigger points are responsible for causing or perpetuating low back pain is controversial and disputed by many experts. Trigger point injections are invasive and not recommended in the treatment of patients with acute low back problems. The injections can expose patients to serious potential complications. The effectiveness of trigger point injection is uncertain, in part due to the difficulty of demonstrating advantages of active medication over injection of saline. Needling alone may be responsible for some of the therapeutic response. The only indication with some positive data is myofascial pain (see the Pain Chapter); may be appropriate when myofascial trigger points are present on examination. (Bigos, 1999) (Colorado, 2001) (Nelemans-Cochrane, 2000) (Vad, 2002) (van Tulder, 2006) (Note: one major evidence based guideline has concluded that trigger point and ligamentous injections are likely to be beneficial for chronic low back pain.) (VanTulder-BMJ, 2004)

**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)