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# IRO REVIEWER REPORT

**DATE OF REVIEW:** 10/17/07

**IRO CASE NO.:**

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

Items in Dispute: Lumbar epidural steroid injections.

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

Texas License
Board Certified Neurosurgeon

**REVIEW OUTCOME:**

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

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. MRI lumbar 12/30/06.
2. Peer review M.D., 01/11/07.
3. Medical records Dr. dated 12/30/06 thru 08/21/07.
4. EMG/NCV study 08/21/07.
5. Starr Comprehensive Solutions Denials 09/04/07, 09/26/07 – ***Official Disability Guidelines included.***

**INJURED EMPLOYEE CLINICAL HISTORY (SUMMARY):**

The employee is a female who is reported to have sustained a low back injury as a result of a slip and fall.

The employee has a longstanding history of low back pain and has continued to work. The employee's back pain gradually increased. The employee was later admitted to the hospital on 12/17/06, and was discharged on 12/24/06. During this admission, the claimant received IV pain medications, and she reports that her pain was not relieved. A MRI of the lumbar spine was performed on 12/30/06. This study indicates multilevel degenerative changes with significant

spinal stenosis at L4-L5. The thecal sac diameter is reported to be just less than 6 mm. There are prominent degenerative changes in the zygapophyseal joints. There is no epidural fat anterolateral to the thecal sac. Compromise of the L5 nerve roots could not be excluded. There is no evidence of extruded disc fragment or mass present.

The employee was seen by Dr. on 02/09/07. At this time, the employee is reported to have back and right hip pain since her injury. Dr. notes that the employee was hospitalized before Christmas, made some recovery, and went home. The employee reports persistent pain in the right hip, and leg, with weakness in the right leg since the injury. The employee is reported to have had a lumbar epidural steroid injection which helped.

On physical examination, the employee is reported to be obese. The employee has back and extremity paraspinal muscle tenderness, and straight leg raising was noted to be 50 degrees on the right. The employee is able to stand and walk with a broad based gait. The employee has a mild foot drop on the right, and reduced ankle jerks were noted bilaterally.

The employee was subsequently referred for electrodiagnostic studies on 08/21/07. The employee is reported to have a chronic left S1 radiculopathy, and a peripheral neuropathy. Two requests have previously been placed for lumbar epidural steroid injections. A later clinic note dated 09/06/07 indicates that Dr. has requested preauthorization to do lumbar facet injections.

Citation:
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| Epidural steroid injections (ESIs), therapeutic | Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although epidural steroid injections have not been found to be as beneficial a treatment for the latter condition.<br>*Short-term symptoms:* The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular pain between two and six 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 three 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)<br>*Use for chronic pain:* Chronic duration of symptoms (> six months) has also been found to decrease success rates with a threefold decrease found in claimant s with symptom duration > twenty-four months. The ideal time of either when to initiate treatment or when treatment is no longer thought to be effective has not been determined. (Hopwood, 1993) (Cyteval, 2006) Indications for repeating epidural steroid injections in claimants with chronic pain at a level previously injected (> twenty-four months) include a symptom-free interval or indication of a new clinical presentation at the level.<br>*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) (Young, 2007) This approach may be particularly helpful in claimant s with large disc |

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| | herniations, foraminal stenosis, and lateral disc herniations. (Colorado, 2001) (ICSI, 2004) (McLain, 2005) (Wilson-MacDonald, 2005)<br>*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) (Young, 2007)<br>*Factors that decrease success:* Decreased success rates have been found in claimant s 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 epidural steroid injections 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) (Delport, 2004) (Khot, 2004) (Buttermann, 2004) (Buttermann2, 2004) (Samanta, 2004) (Cigna, 2004) (Benzon, 2005) (Dashfield, 2005) (Arden, 2005) (Price, 2005) (Resnick, 2005) (Abdi, 2007) (Boswell, 2007) Also see Epidural steroid injections, "series of three" and Epidural steroid injections, diagnostic. epidural steroid injections may be helpful with radicular symptoms not responsive to two to six weeks of conservative therapy. (Kinkade, 2007) 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 two additional visits to reinforce the home exercise program.<br>**Criteria for the use of Epidural steroid injections:**<br>*Note: The purpose of epidural steroid injection 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.*<br>(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)<br>(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).<br>(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.<br>(4) At the time of initial use of an epidural steroid injection (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.<br>(5) No more than two nerve root levels should be injected using transforaminal blocks.<br>(6) No more than one intralaminar level should be injected at one session.<br>(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)<br>(8) Repeat injections should be based on continued objective documented pain and functional response. |

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| | (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.<br>(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. |

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| Epidural steroid injections, "series of three" | Not recommended. Original recommendations that suggested a "series of three injections" generally did so prior to the advent of fluoroscopic guidance. These previous recommendations were based primarily on case studies and anecdotal evidence (Class IV and V data). (Abram, 1999) (Warr, 1972) (Hickey, 1987) Contemporary research studies with higher levels of evidence (including two controlled trials) have suggested that on average, two or less epidural steroid injections are required in claimant s with successful outcomes from the use of epidural steroid injections to treat disc related lumbar radiculopathy. (Lutz, 1998) (Vad, 2002) (Riew, 2000) While all of these latter studies have utilized repeat injections, there has been no evidence-based research to explain why this practice is required, or the mechanism for possible action. Since the introduction of fluoroscopically guided epidural steroid injections, it has been suggested that there is little evidence to repeat an accurately placed epidural injection in the presence of mono-radiculopathy, regardless of whether there is partial or no response. (McLain, 2005) A recent randomized controlled trial of blind epidural steroid injections found no evidence to support repeat injections, because at six weeks there was no significant difference found between the epidural steroid injection group and a placebo controlled group in terms of any measured parameter. (Price, 2005) A repeat injection has been suggested if there is question of accurate dermatomal diagnosis, if pain may be secondary to a different generator, or in the case of multilevel pathology. (McLain, 2005) With fluoroscopic guidance, there is little support to do a second epidural if there is no response to the first injection. There is little to no guidance in current literature to suggest the basis for the recommendation of a third epidural steroid injection, and the routine use of this practice is not recommended. |

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

The request for lumbar epidural steroid injection is not supported by the submitted medical documentation. The available medical record indicates that the employee has right lower extremity radicular symptoms manifesting as right EHL weakness and absence of the right Achilles reflex. The record does not indicate that the employee has a sensory deficit. It is further noted that the employee has a history of diabetes, which would be a relative contraindication to corticosteroid injections. I would further note that the employee has undergone electrodiagnostic studies which find evidence of a chronic left S1 radiculopathy, and the employee's current symptoms are reported to be right sided. Provided this information, I would concur with the previous reviewers that the request for lumbar epidural steroid injections is not supported by the current clinical information.

If the IMED's decision is contrary to: (1) the DWC's policies or guidelines adopted under Labor Code §413.011, IMED must indicate in the decision the specific basis for its divergence in the review of medical necessity of non-network health care or (2) the networks treatment guidelines, IMED must indicate in the decision the specific basis for its divergence in the review of medical necessity of network health care.

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

A. ***Official Disability Guidelines***