

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 12/30/2008

**IRO CASE #:**

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

Lumbar epidural steroid injection with fluoroscopy

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

Certified by The American Board of Anesthesiology

**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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	724.2	62311	Overturned

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Determination letters for initial and reconsideration requests  
Physician note dated 10/28/08  
MRI dated 9/30/08

**PATIENT CLINICAL HISTORY:**

This xx-year old claimant injured his back on xx/xx/xx, while pulling a bag cart at work. The claimant reports that he immediately felt low back and right lower

extremity pain. The claimant was treated with conservative therapy and two weeks of physical therapy with only mild improvement. Evaluation of 10/28/08, noted continued complaints of low back and right lower extremity pain. Physical examination revealed a positive straight leg raise on the right along with tingling in the right L4 and L5 dermatomes. A MRI performed on 9/30/2008 revealed a mild annular disc bulge at L5-S1 with mild right neural foraminal narrowing. At L4-5 there was a small broad based right paracentral disc protrusion with ligamentum flavum thickening that results in mild central canal narrowing and asymmetric right subarticular recess narrowing.

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

In the Reviewer's opinion, lumbar epidural steroid injection with fluoroscopy is indicated for this claimant based on the following:

Per ODG, epidural steroid injections are:

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. 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.

Per ODG, the criteria for epidural steroid injections are:

#### **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. 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) *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 required. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of 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.)

Per review of the clinical note dated 10/28/08, all the criteria for the requested procedure have been met. Of note, there is no requirement per ODG that a MRI be completed prior to the performance of an epidural steroid injection.

**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)**