

SENT VIA EMAIL OR FAX ON  
Dec/19/2008

## IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/17/2008

**IRO CASE #:**

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

lumbar epidural steroid injection

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Subspecialty Board Certified in Electrodiagnostic Medicine

Residency Training PMR and ORTHOPAEDIC SURGERY

**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)

**PATIENT CLINICAL HISTORY SUMMARY**

This xx year old man was injured when his truck was hit by a fork lift. He was jerked and sustained neck and low back pain. I have not been requested to discuss the cervical issue. That was address in an administrative hearing (7/11/08 edited and reviewed 8/7/08).

He complained of back pain and left leg numbness. Several people reviewed his lumbar MRI. No formal report was provided. He had either normal studies or disc bulges at L4/5 and L5/S1. He had an emg that showed a chronic:L5 radiculopathy based on spontaneous potentials in the medial gastrocnemius and the peroneus longus. The paraspinal muscles were normal.

Dr. 's examination and review described back pain, with lower extremity numbness and tingling, especially at night. It was bilateral, but the left side was more symptomatic. His examination found no neurological abnormalities. He cited a prior back injury that healed.

Dr. first saw this man on 3/11/08. He described back pain and pain in both legs and the left foot. He described reduced left L5 sensation as the only neurological finding. Motor strength was normal. He cited the 12/20/07 EMG findings and wrote that the MRI was "unremarkable of the lumbar spine." He had also commented upon L4/5 and L5/S1 bulges at other times. This man had a lumbar epidural injection on 4/18/08 that reportedly helped and gave 70% symptom relief (Dr. 10/24/08) =. He wrote that this man had a lumbar strain on 5/15/08. He commented on 5/13/08 that the benefits of the lumbar epidural injection had worn off. In fact, he had more leg pain after the injection (4/24/08 note). His examination found limited lumbar motion. Local tenderness, but a normal neurological exam. He wrote "the pathology in the cervical spine is more significant than that of the lumbar spine."

Dr. described lumbar myofascial pain even with the reported left L5 radiculopathy on EMG.

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

This man injured his back in the xxxx accident. He had a prior back injury that previously resolved. He had a normal neurological examination cited on several occasions with the exception of the reduced L5 sensation. The lumbar MRI was generally normal, even with the disc bulges. The EMG had the left L5 radiculopathy. His clinical improvement lasted less than a month following the lumbar ESI.

The ODG requires documentation of a radiculopathy. The positive EMG does this. The lack of motor findings and the subjective sensory complaints can be seen with normal MRIs if there is chemical irritation of the nerve roots with limited loss of motor axons. Hence, there may be no weakness, but there is the abnormal EMG finding. The ODG requires a 50-70% benefit from epidural steroid injections and the benefits must last 6-8 weeks before a second injection is warranted. This man had less than a month of relief, which is consistent with the AAN findings. The short duration of relief does not meet the ODG requirements for a repeat injection.

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) 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

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 or return to work. 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

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. 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 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...

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.... ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. (Kinkade, 2007) Epidural steroid injections are an option for short-term pain relief of persistent radiculopathy, although not for nonspecific low back pain or spinal stenosis. (Chou, 2008) 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 2 additional visits to reinforce the home exercise program

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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.)

Epidural steroid injections, “series of three

Not recommended...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) There is a lack of support for 2nd epidural steroid injection if the 1st is not effective. (Cuckler, 1985) 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 ESI, and the routine use of this practice is not recommended.

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

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A  
DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES  
(PROVIDE A DESCRIPTION)