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**DATE OF REVIEW:** 12/09/2008

**IRO CASE #:**

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

Lumbar epidural w/fluoroscopy & 4-6 trigger point injections.

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

This case was reviewed by a Texas licensed MD, specializing in Physical Medicine & Rehabilitation. The physician advisor has the following additional qualifications, if applicable:

ABMS Physical Medicine & Rehabilitation

**REVIEW OUTCOME:**

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

UPHELD

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Lumbar epidural w/fluoroscopy & 4-6 trigger point injections.			UPHELD

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The date of injury is listed as xx/xx/xx. It is documented that the claimant developed difficulty with low back pain when the claimant performed a lifting activity in the work place.

A lumbar MRI obtained on 12/7/06 revealed findings consistent with a disc bulge at the L4-L5 level, as well as a right sided disc herniation at the L5-S1 disc level.

A physician assessment dated 2/12/07 indicated that previous treatment included treatment in the form of 3 lumbar epidural steroid injections. There was a positive benefit to the first 2 injections, but no benefit was obtained from the third injection. It was also documented that there were no radicular symptoms noted.

A lumbar epidural steroid injection was performed on 4/30/07.

A designated doctor evaluation was conducted on 8/31/07, and on this date, the claimant was placed at a level of maximal medical improvement.

A physician assessment was accomplished on 10/2/07, at which time, it was documented that a lumbar epidural steroid injection was provided on 8/30/07, and this injection decreased pain symptoms, overall, by approximately 30%.

A lumbar epidural steroid injection was provided to the claimant on 2/20/08. A physician note dated 3/18/08 indicated that the procedure performed on 2/20/08 provided overall, a reduction in pain symptoms of approximately 20%.

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

Item in Dispute: Consideration for treatment in the form of a lumbar epidural steroid injection as well as trigger point injections.

Based upon the documentation presently available for review, the submitted documentation does not provide sufficient data to support a medical necessity for treatment in the form of a lumbar epidural steroid injection as well as treatment in the form of trigger point injections. The records available for review document that past treatment in the form of lumbar epidural steroid injections did not appear to markedly decrease pain symptoms. Additionally, the records available for review did not appear to reveal the presence of consistent radicular symptoms on physical examination. Per criteria set forth by Official Disability Guidelines, there was not a sufficiently positive response to previous treatment in the form of lumbar epidural steroid injections to support a medical necessity for a repeat lumbar epidural steroid injection at the present time. Additionally, Official Disability Guidelines provide very strict criteria with respect to utilization of trigger point injections for management of pain symptoms. Based upon the criteria set forth per the above noted reference, it would not appear that there are sufficient findings on physical examination to support a medical necessity for treatment in the form of trigger point injections at the present time. Additionally, the records available for review do not document that there was a markedly long term positive response to previous treatment in the form of trigger point injections. Consequently, based upon the documentation presently available for review, Official Disability Guidelines do not provide criteria to support a medical necessity for treatment in the form of trigger point injections or a repeat lumbar epidural steroid injection at the present time.

**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.)

Not recommended in the absence of myofascial pain syndrome. See Criteria for use below. See the [Pain Chapter](#) for more information and references. The primary goal of trigger point therapy is the short-term relief of pain and tightness of the involved muscles in order to facilitate participation in an active rehabilitation program and restoration of functional capacity. The evidence for TPIs when used as a sole treatment for patients with chronic low-back pain (regardless of injectate) is inconclusive and the treatment does not appear to be more effective than treatments such as laser or ultrasound. 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. These injections are not recommended for typical chronic low back or neck pain, nor are they recommended for radicular pain. ([Scott, 2005](#)) ([Scott, 2008](#)) The advantage appears to be in enabling patients to undergo remedial exercise therapy more quickly. TPIs are generally considered an adjunct rather than a primary form of treatment and should not be offered as either a primary or a sole treatment modality. Steroid injection is not generally recommended nor is Botulinum toxin. ([Bigos, 1999](#)) ([Nelemans-Cochrane, 2000](#)) ([Vad, 2002](#)) ([BlueCross BlueShield, 2004](#)) ([van Tulder, 2006](#)) ([VanTulder-BMJ, 2004](#)) ([Peloso, 2007](#)) ([Ho, 2007](#))

#### **Criteria for the use of Trigger point injections:**

Trigger point injections with a local anesthetic with or without steroid may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief with reduced medication use is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended; (9) There should be evidence of continued ongoing conservative treatment including home exercise and stretching. Use as a sole treatment is not recommended; (10) If pain persists after 2 to 3 injections the treatment plan should be reexamined as this may indicate an incorrect diagnosis, a lack of success with this procedure, or a lack of incorporation of other more conservative treatment modalities for myofascial pain. It should be remembered that trigger point injections are considered an adjunct, not a primary treatment.

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

ODG

