



## IMED, INC.

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 04/21/09

**IRO CASE NO.:**

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

Item in dispute: Transforaminal epidural steroid injection #2 at L4-L5

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

Board Certified in Physical Medicine & Rehabilitation  
Fellowship Trained in Pain Management

**REVIEW OUTCOME**

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

Denial Overturned

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY (SUMMARY):**

According to the medical records provided, the employee was a xx-year-old female who was employed as a that was involved in a motor vehicle accident on xx/xx/xx. This occurred while she was on the job. She was a restrained passenger and was injured in a T-bone type injury. The car was completely destroyed. She began to have an immediate headache, and although she did not remember exact details she could not

remember whether or not she lost consciousness. She had to be extricated from the vehicle and was taken to the emergency room where she underwent multiple studies.

On 11/10/08 the employee saw Dr. at the . At that time, she was complaining of headaches. She did not think her memory was quite as good as it used to be. She had pain in the back of her head. She had pain in her left shoulder and pain in her left hip greater than right with radiation down the left leg that went all the way to the foot. She had a burning type sensation consistent with possible nerve root compression. She was on medications. Past medical history included hypertension and past surgical history was removal of a tumor near her colon and LAP band surgery. She had no allergies. Current medications were Avalide, Naprosyn, Robaxin, and Vicodin. Her social history noted her work as a and . She had no children, did not smoke, and was not married. Imaging studies were reviewed by Dr. which included a CT scan of the lumbar spine from 10/12/08 that revealed a fracture of the transverse process of L2. Thoracic spine was unremarkable. CT of the head was unremarkable. Shoulder series was performed which he did not read. CT of the chest and abdomen was negative. In physical examination, the employee showed some confusion of the actual events of the accidents. Her face was symmetric and speech was normal, as was hearing. Cranial nerves were intact. Upper extremity sensory, motor, reflexes, and coordination were intact. There was some soreness of the outer left shoulder noted. The low back showed positive straight leg raise on the left at 82-85 degrees. Knee reflexes were both 1+. Ankle reflexes were 1+. Sensation was essentially normal, but the employee described pain that radiated down her left leg below her knee and somewhat in the mid calf lateral aspect. Tenderness with hyperextension, tenderness to deep palpation and mild pain with flexion was noted. The impression was closed head injury, mild concussion, and fracture L2 transverse process. The recommendation was to continue conservative care, and Dr. was a little concerned of the radiating pain down the leg. He recommended an MRI of the lumbar spine and follow-up afterward.

On 12/12/08, the employee followed up at and was seen by , P.A. On physical examination, the employee was awake, alert, and oriented and under no acute distress. She was able to ambulate, and the lower extremities showed 5/5 distal motor strength. Dorsiflexion and plantar flexion were 5/5. Sensation was intact bilaterally. Reflexes were equal, and there were no pathological reflexes. The employee complained of ongoing pain that radiated to her hips and to some extent down the lower extremity. MRI of the lumbar spine was reviewed with the employee, which showed degenerative disc disease, more prominent in the lower lumbar spine. Canal was patent. There was no obvious nerve root compression or cord compression. Assessment found the employee to be status post motor vehicle accident with axial pain and left radicular symptoms to the knee only. The plan, given the ongoing symptoms despite no obvious disc herniation or cord compression, was to send for physical therapy and pain management. The reason was for possible evaluation of epidural steroid injection or facet blocks. The employee was told she could return to work on 01/15/09 for a desk job at four hours a day and was to perform no heavy lifting. She was to follow-up after physical therapy and epidural steroid injections.

On 01/09/09, the employee received a lumbar epidural steroid injection at L4-L5 and L5-S1 on the left hand side. She received approximately 70% relief for three days after the

epidural steroid injection. The treating physician was Dr. . The plan after the epidural steroid injection was to follow-up in two weeks for a repeat epidural steroid injection.

What followed was an adverse determination letter for denial of the second transforaminal epidural steroid injection.

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

The previous denial for transforaminal epidural steroid injection at L4-L5 is overturned. The employee has clinical evidence of a lower extremity radiculopathy and has been afforded one epidural steroid injection. The employee received 70% relief during the diagnostic phase, and a second injection is supported by the **Official Disability Guidelines**. The guidelines under diagnostic phase of these criteria states that the time of initial use of an epidural steroid injection a maximum of one to two injections should be performed, and based on the verbiage from #7 therapeutic phase, if after the initial block/blocks are given and found to produce pain relief of at least 50% to 70% pain relief for at least six to eight weeks, additional blocks may be required, the decision at this time is to allow the use of a second transforaminal epidural steroid injection. There is evidence of clinically documented radiculopathy on examination, and based on these guidelines, up to two injections can be given in the initial phase of treatment.

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

Current **Official Disability Guidelines** concerning the criteria for use of steroid injections are as follows: 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.)