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**DATE OF REVIEW:** 08/04/2009

**IRO CASE #:**

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

LT L3-L4, L4-L5 Epidural Steroid Injection with fluoroscopy

**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 DO, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

AOA Orthopaedic Surgery

**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
LT L3-L4, L4-L5 Epidural Steroid Injection with fluoroscopy	99144, 77003, 64484, 64483	-	Upheld

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

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request		14		
2	First Report of Injury		1	01/23/2009	01/23/2009
3	Initial Denial Letter	Corporation	5	05/29/2009	06/19/2009
4	Diagnostic Test	Orthopaedic Surgery Group	1	04/16/2009	04/16/2009
5	Claim Dispute Notice	Solutions	2	01/07/2009	05/21/2009
6	Office Visit Report	Orthopaedic Surgery	23	01/28/2009	06/17/2009

		Group			
7	PT Notes	Physical Therapy Services	17	02/05/2009	03/11/2009
8	Peer Review Report	MD	5	05/07/2009	05/07/2009
9	IRO Request		15	07/13/2009	07/16/2009

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Pt is a female who was injured at work on xx/xx/xx when she fell onto her buttock area, causing injury to her lower back and thoracic and cervical regions.

The patient was treated with activity modification, physical therapy, anti-inflammatory medications, and pain medications.

In March of 2009, patient was sent for an MRI, which revealed small left foraminal disc herniation at L3-4, disc herniation at L4-5, and moderate left foraminal narrowing at L3-4 and L4-5.

On April 22, 2009, the patient was taken off work completely and this was expected to last for one month.

On 5/22/2009, the patient was seen by Dr. who recommended transforaminal epidural steroid injections on the left at L3-4 and L4-5, both as a therapeutic and diagnostic step to help her pain and radiculopathy. However, the physical exam did not specify that there was loss of sensation in dermatomal patterns, only referral of pain. Physical exam did not specify findings that would specifically indicate a diagnosis of radiculopathy.

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

The patient has some pre-existent degenerative changes of her lumbar spine, and the injury of xx/xx/xx has been reviewed previously and determined to be an exacerbation or aggravation of these conditions. I concur with this assessment. After thorough review of her medical records, I do not believe that the physical examinations presented through copious medical records reviewed, support a diagnosis of true radiculopathy. Therefore, according to ODG guidelines, epidural steroid injections would not be expected to result in material improvement in her condition and would not be indicated in this case.

For these reasons, I respectfully submit for adverse determination regarding epidural steroid injections at this time.

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

ODG:

Low Back Chapter: 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” injection 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.)

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