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DATE OF REVIEW: 05/01/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Lumbar epidural steroid injections L4/5, S1

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

Board Certified Family Practice

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

1. MRI of the lumbar spine dated 02/24/09.
2. Clinical notes Dr. dated 06/27/05, 02/05/09, and 03/05/09.
3. EMG/NCV study dated 03/23/09.
4. Utilization review determination dated 03/17/09.
5. Utilization review determination dated 04/08/09.
6. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who has a date of injury of xx-xx-xx. The nature and type of injury was not described in the medical record.

The first available clinical record was dated 06/27/05, and on this day the employee was seen by Dr.. The employee was reported to have last been seen in August, 2004. He continued Celebrex and ibuprofen for pain and had worsening left buttock and left leg pain. The employee had a diagnosis of lumbar radicular syndrome.

The employee was not seen again in follow-up until 02/05/09. The employee reported that he continued to experience low back pain with radiation into the posterior left leg.

His imaging studies were reported to be dated, and he had difficulty obtaining medications due to the compensation system. He had recently had a fractured ankle.

Upon examination, the employee had tenderness in the left at L4-L5 and L5-S1. Flexion was more painful than extension. Sensory was intact and manual motor testing could not be evaluated. He had positive sitting root test on the left and negative on the right.

The employee was subsequently referred for repeat MRI on 02/24/09. This study reported a transitional level with the most inferior disc space being regarded as L5-S1. There is congenital narrowing of the spinal canal from L2-3 through L4-5. At L4-5, there was a broad-based ventral defect representing posterior osteophytes with a disc protrusion which slightly exceeded the bony margins. There was degenerative facet joint changes and prominent epidural fat. There was a 3 mm broad-based disc protrusion at L3-L4 with degenerative facet joint changes and prominent posterior epidural fat. The diameter of the canal is 7-8 mm. At L5-S1, there was a broad-based ventral defect representing the combination of disc and spur without deformity of the thecal sac or S1 nerve root sleeves. There was asymmetric extension to the left neural foramen and possible contact of the left L5 nerve root.

When seen in follow-up, the employee's radiculopathy was reported to be worse. It was reported that his leg gave way a few weeks previously, and he had a 3rd degree sprain of his left ankle. Dr. recommended lumbar epidural steroid injections.

The employee was later referred for electrodiagnostic studies on 03/23/09. This study indicated evidence of a left S1 radiculopathy.

A previous utilization review was performed on 03/17/09. The reviewing provider recommended against lumbar epidural steroid injections. His reason for denial was that the recent lumbar MRI did not reveal the presence of a compressive lesion upon any of the neural elements.

This case was appealed and reviewed on 04/08/09. This reviewer reported that the employee had previously had epidural steroid injections; however, there was no documentation of his specific response to prior epidural steroid injections and there was no data to indicate how long it had been since his prior epidural steroid injections.

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

Based upon the submitted clinical records, the request for lumbar epidural steroid injection is considered medically necessary and supported by the **Official Disability Guidelines**. The records as submitted indicate that the employee sustained an injury to his low back on xx-xx-xx. Records indicate that the employee has been treated conservatively over the past several years and has a long-standing lumbar radicular syndrome. The most recent imaging study indicates a left lateralizing disc protrusion

with possible contact of the left L5 nerve root, and the employee has undergone electrodiagnostic studies which indicate a left S1 radiculopathy.

The employee's symptoms correlate with his physical examination, and there was no documentation submitted which indicates that the employee has previously undergone any lumbar epidural steroid injections. The employee has clinical evidence of a lumbar radiculopathy which correlates with both his imaging studies and EMG/NCV study, and therefore, under the **Official Disability Guidelines**, a single lumbar epidural steroid injection would be considered medically necessary.

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

The Official Disability Guidelines, 13th Edition, The Work Loss Data Institute.
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, although ESIs have not been found to be as beneficial a treatment for the latter condition.

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. (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. ([1986](#)) ([1999](#)) ([2005](#)) ([2005](#)) ([2005](#))

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. ([1993](#)) ([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.

Transforaminal approach: Some groups suggest that there may be a preference for a transforaminal approach as the technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. ([2000](#)) ([2002](#)) ([2007](#)) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations. ([2001](#)) ([2004](#)) ([2005](#)) ([2005](#))

Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. ([1999](#)) ([2001](#)) ([ICSI, 2004](#)) ([Molloy, 2005](#)) ([Young, 2007](#))

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. ([1997](#)) ([1999](#)) ([1999](#)) ([2002](#)) ([2003](#)) ([2004](#)) ([2004](#)) ([2004](#)) ([2004](#)) ([2, 2004](#)) ([2004](#)) ([2004](#)) ([2004](#)) ([2005](#)) ([2005](#)) ([2005](#)) ([2005](#)) ([2005](#)) ([2007](#)) ([2007](#)) Also see [Epidural steroid injections, "series of three"](#) and [Epidural steroid injections, diagnostic](#). ESIs may be helpful with radicular symptoms not responsive to 2 to 6 weeks of conservative therapy. ([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. ([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.

With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. ([2008](#))

An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. ([2009](#)) Recent studies document a 629% increase in expenditures for ESIs, without demonstrated improvements in patient outcomes or disability rates. ([2009](#))

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. ([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](#)) ([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).