



## IMED, INC.

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 03/24/10

**IRO CASE NO.:**

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

Item in dispute: Lumbar epidural injection under fluoroscopy

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

Texas Board Certified PM&R  
Fellowship Trained Pain Management

**REVIEW OUTCOME**

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

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. MRI of the lumbar spine dated 11/24/97 Imaging
2. Clinic note dated 12/22/09 Dr.
3. Clinic note dated 12/28/09 Dr.
4. Clinic note dated 01/28/10 Dr.
5. Prior review dated 02/04/10 from xxxxx
6. Clinic note dated 02/15/10 Dr.
7. Prior review dated 02/22/10 from xxxxxx
8. **Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee was when he injured his low back. The mechanism of injury is unknown per documents submitted. The employee complained of low back pain that radiated to his lower extremity.

An MRI dated 11/24/97 revealed a disc protrusion at L2-L3. At L5-S1, there was evidence of a laminectomy and discectomy with no canal stenosis, no significant postoperative scar or significant residual disc extrusion seen. There was spondylosis with bilateral facet joint arthrosis and mild bilateral foraminal narrowing.

A clinic note dated 12/22/09 revealed the employee underwent a lumbar epidural steroid injection in August of 2009 and received 80-90% relief of his pain for four months; however, his pain has returned. He has been treated with rest, an exercise program

and medications without improvement. The employee had a spinal cord stimulator which was analyzed and appeared to be functioning properly. This was reprogrammed at that time. The employee was recommended to undergo a series of two lumbar epidural injections under fluoroscopic imaging and trigger point injections.

A clinic note dated 01/28/10 stated that the employee received a second epidural steroid injection on 01/20/10 and received 90% pain relief with the injection; however, he had a return of some of his pain. The physical examination showed the employee had reproducible trigger point tenderness noted to the quadratus lumborum, the gluteus maximus, and gluteus medius. There was limited range of motion in the lumbar spine secondary to pain. He has to lift his left leg with his hand. The spinal cord stimulator again was reprogrammed, and a request was made for another lumbar epidural steroid injection with trigger point injections to be performed two weeks apart.

A clinic note dated 02/15/10 was an appeal for the epidural steroid injection and it was stated that the employee is in the therapeutic phase and a third injection was requested as he had received 80% relief of his pain for six weeks.

A peer review dated 02/22/10 also denied the request for the third lumbar epidural steroid injection as the request appears to be for a third injection and as the second injection was given on 01/20/10 with 90% reduction in pain, it was not clear that this pain relief lasted for six to eight weeks.

A peer review dated 02/24/10 shows that the request for the third epidural steroid injection was denied as the second injection given on 01/20/10 showed 90% reduction in pain but not clearly lasting for six to eight weeks. There was also not an imaging study that correlates nerve compression with the employee's symptoms or signs. There was no evidence of improvement in function over time.

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

The medical necessity is not established for the requested epidural steroid injection. The criteria per current guidelines for repeat epidural steroid injections states that there should be continued objective documented pain relief with a decreased need for pain medication and functional response. The clinic notes submitted do not show that the employee had a reduction in pain medication usage and an increase in functional response. Additionally, the clinic note dated 01/28/10 states that the employee was given an injection on 01/20/10 with 90% pain relief; however, the employee had return of pain. This would indicate that the employee had less than eight days of relief from this injection and current guidelines recommend repeat injections be recommended for individuals with 50-70% pain relief for six to eight weeks. Additionally, the clinic notes submitted did not show that the employee has objective findings consistent with radiculopathy and as epidural steroid injections are recommended for individuals with documented radiculopathy, the medical necessity is not established for the repeat epidural steroid injection under fluoroscopy. Therefore, the decision is to uphold the denial for the requested epidural steroid injections under fluoroscopy.

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

Official Disability Guidelines, 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” 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.)