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Notice of Independent Review Decision

DATE OF REVIEW: 09/20/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Lumbar Epidural Steroid injection, Epidurogram, and interpretation under Fluoroscopy
CPT: 62311, 72275, 77003

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

Texas Board Certified Orthopedic Surgeon

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. Operative report dated 04/20/96
2. Functional Capacity Evaluation
3. Operative report dated 04/22/98
4. Clinic notes, Dr. dated 02/25/10, 05/03/10, 05/27/10
5. MRI of lumbar spine with and without contrast dated 06/21/10
6. Previous utilization review determination dated 07/26/10
7. Previous utilization review determination dated 08/06/10
8. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who has a date of injury of xx/xx/xx. The medical record does not include a mechanism of injury or conservative treatment to date.

On 04/20/96, records indicate the employee underwent an L4-L5, L5-S1 decompression, posterolateral fusion.

On 04/22/98, the employee underwent exploration of fusion, removal of hardware, pseudoarthrosis repair, and anterior lumbar interbody fusion at L4-L5.

The employee was seen in follow-up by Dr. on 02/25/10. She was reported to have low back pain and spasms with left leg pain. Current medications include 3-4 Darvocet and 3 Flexeril per day. She was reported to have lost 40 pounds of weight. She had not been able to decrease her amount of oral medications. She complained of back pain and left leg numbness upon walking. Range of motion of the lumbar spine was diminished. Foraminal compression test was equivocal. Straight leg raise was equivocal at 50 degrees. Strength was diminished by ½ grade in the right foot. Sensation was variable. Knee jerks are 2+ and ankle jerks were trace bilaterally.

The employee was seen in follow-up on 05/03/10. Her clinical situation was unchanged. Her physical examination was grossly unchanged.

The employee was seen in follow-up on 05/26/10. At that time, she was reported to have continued low back pain with muscle spasms and left leg pain. Her medication profile remained the same. It was reported with walking she gets cramps in her legs. She was reported to have intermittent claudication. On physical examination, the employee had reduced lumbar range of motion. She had paralumbar spasms. Foraminal compression test was reported to be positive. Straight leg raise was equivocal on left at 60 degrees. Femoral nerve stretch was positive on left. Strength was reported to be diminished as 4/5 in left quads with ½ grade loss in right and left foot. Sensation was decreased in left lateral thigh. Knee jerks were trace on the left and 2+ on right. Ankle jerks were trace bilaterally.

The employee was referred for MRI of the lumbar spine dated 06/21/10. This report indicated a history of discectomies at L4-L5 and L5-S1. There was mild broad-based disc bulge at L2-L3 and another at L3-L4. These minimally indented the thecal sac. The thecal sac at L4-L5 and L5-S1 and central canal were large. There were hypertrophic facet degenerative changes at L3-L4 on the right with mild foraminal narrowing as consequence. Hypertrophic changes were noted in facet joints on the left at L3-L4, L4-L5 and L5-S1. There was mild foraminal narrowing on the left at L3-L4 and L4-L5. A request was placed by Dr. for lumbar epidural steroid injection.

On 07/26/10, the request for lumbar epidural steroid injection was reviewed by Dr.. Dr. conducted a peer to peer review with Dr.. She recommended against certification. She noted the MRI showed bulges but no herniated nucleus pulposus or other nerve root impingement and reported the request failed to meet **Official Disability Guidelines**. It was further reported the requestor never suggested an epidural steroid injection on latest note and even stated the employee could return to work with restrictions. Dr. opined there was no consistent rationale for this injection.

On 08/06/10, the case was reviewed by Dr.. Dr. conducted a peer-to-peer review with Dr.. He reported he was critical of previous reviewer and the system. He offered the employee suffered from canal stenosis proximal to the previous fusions. Dr. opined the faxed MRI dated 06/21/10 did not support diagnosis.

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

The submitted clinical records indicate the employee initially sustained an injury to her low back on xx/xx/xx. Records indicated the employee underwent fusion at L4-L5, L5-S1 on 04/20/96.

The employee was later opined to have pseudoarthrosis at the L4-L5 level. She was subsequently returned to surgery on 04/22/98 and underwent exploration of fusion and anterior lumbar interbody fusion at the L4-L5 level secondary to pseudoarthrosis. Postoperatively the employee appeared to have a chronic history of low back pain. More recent clinic notes indicate that the employee was treated with oral pain medications, she was not working, her physical examination is consistent with history; however, on 05/27/10 the employee appeared to have developing of progressive neurologic deficit. The notes as submitted for review do not provide any clinical information regarding this observation and subsequent documentation of treatment plan. Imaging studies do not indicate any significant neurocompressive lesions above the level of previous fusion.

Based upon the data, the employee does not meet criteria per **Official Disability Guidelines** for the performance of lumbar epidural steroid injection. Noting the lack of clinical history regarding previous possible injections, and noting the lack of neurocompressive pathology identified on recent imaging studies, the requested lumbar epidural steroid injections would not be medically necessary or supported under ODG.

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

The 2010 *Official Disability Guidelines*, 15th Edition, The Work Loss Data Institute. Online edition.

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. ([Armon, 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. ([Benzon, 1986](#)) ([ISIS, 1999](#)) ([DePalma, 2005](#)) ([Molloy, 2005](#)) ([Wilson-MacDonald, 2005](#)) This recent RCT concluded that both ESIs and PT seem to be effective for lumbar spinal stenosis for up to 6 months. Both ESI and PT groups demonstrated significant improvement in pain and functional parameters compared to control and no significant difference was noted between the 2 treatment groups at 6 months, but the ESI group was significantly more improved at the 2nd week. ([Koc, 2009](#))

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. ([Hopwood, 1993](#)) ([Cyteval, 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. ([Riew, 2000](#)) ([Vad, 2002](#)) ([Young, 2007](#)) This approach may be particularly helpful in patients with large disc herniations, foraminal stenosis, and lateral disc herniations. ([Colorado, 2001](#)) ([ICSI, 2004](#)) ([McLain, 2005](#)) ([Wilson-MacDonald, 2005](#))

Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. ([Manchikanti, 1999](#)) ([Colorado, 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. ([Carette, 1997](#)) ([Bigos, 1999](#)) ([Rozenberg, 1999](#)) ([Botwin, 2002](#)) ([Manchikanti, 2003](#)) ([CMS, 2004](#)) ([Delpont, 2004](#)) ([Khot, 2004](#)) ([Buttermann, 2004](#)) ([Buttermann2, 2004](#)) ([Samanta, 2004](#)) ([Cigna, 2004](#)) ([Benzon, 2005](#)) ([Dashfield, 2005](#)) ([Arden, 2005](#)) ([Price, 2005](#)) ([Resnick, 2005](#)) ([Abdi, 2007](#)) ([Boswell, 2007](#)) ([Buenaventura, 2009](#)) 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. ([Kinkade, 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. ([Chou, 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. ([Rasmussen, 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. ([Staal-Cochrane, 2009](#)) Recent studies document a 629% increase in expenditures for ESIs, without demonstrated improvements in patient outcomes or disability rates. ([Devo, 2009](#)) There is fair evidence that epidural steroid injection is moderately effective for short-term (but not long-term) symptom relief. ([Chou3, 2009](#)) This RCT concluded that caudal epidural injections containing steroids demonstrated better and faster efficacy than placebo. ([Sayegh, 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. ([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.)