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Notice of Independent Review Decision

DATE OF REVIEW: 09/16/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient (OP) Interlaminar epidural steroid injection (ESI), L4-5

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 MD, specializing in Anesthesiology. The physician advisor has the following additional qualifications, if applicable:

ABMS Anesthesiology
 ABMS Anesthesiology

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
Outpatient (OP) Interlaminar epidural steroid injection (ESI), L4-5	62311	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	Appeal Approval Letter		17		
2	Office Visit Report	MD	2	07/29/2010	08/02/2010
3	Office Visit Report	DC	1	08/23/2010	08/23/2010
4	Appeal Denial Letter		4	08/23/2010	08/25/2010
5	IRO Request		10	08/20/2010	08/30/2010
6	Peer Review Report		8	08/05/2010	08/25/2010
7	RME	MD	9	11/11/2009	11/11/2009
8	Initial Denial Letter		3	06/07/2010	06/07/2010
9	Initial Denial Letter		2	08/05/2010	08/05/2010
10	Archive		39	09/09/2010	09/09/2010
11	Office Visit Report	Health & Rehabilitation Center	121	02/01/2010	04/05/2010
12	Claim File		2	11/25/2009	04/14/2010
13	Diagnostic Test	Imaging Center	4	03/23/2009	05/29/2009
14	Diagnostic Test		2	05/13/2004	05/13/2004
15	Diagnostic Test	Orthoped & Neurological	3	05/07/2004	05/07/2004
16	Office Visit Report	Medical Center Hospital	45	05/02/2010	07/19/2010

17	FCE Report	Health & Rehabilitation Center	11	03/31/2009	11/17/2009
18	IRO Request		11	08/05/2010	08/30/2010
19	Op Report	Surgery Center	6	05/15/2009	09/21/2009
20	Office Visit Report	MD	11	02/12/2009	12/15/2009
21	Office Visit Report	MD	7	02/16/2010	06/22/2010
22	Office Visit Report	DO	9	05/24/2004	12/18/2007
23	Office Visit Report	MD	4	05/20/2010	08/02/2010
24	Office Visit Report	MD	2	04/28/2010	04/28/2010
25	Office Visit Report	PA	4	06/24/2009	06/24/2009
26	Office Visit Report	DC	4	03/23/2009	08/23/2010
27	Peer Review Report		8	08/05/2010	08/25/2010
28	Archive		2	11/14/2008	11/18/2008
29	Psych Evaluation	PhD	3	08/14/2009	08/14/2009
30	RME	MD	9	11/11/2009	11/11/2009
31	Initial Denial Letter		3	06/07/2010	06/07/2010
32	Initial Denial Letter		6	08/05/2010	08/25/2010
33	Archive		263	11/14/2008	08/30/2010
34	Archive		277	09/10/2010	09/10/2010
35	Claim File		10		
36	Claim File		17		

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a female whose date of injury is xx/xx/xx. Records indicate the patient lifted a box weighing approximately 30 pounds and experienced acute low back pain. MRI of the lumbar spine dated 05/29/09 reported moderate disc desiccation of the L5-S1 intervertebral disc with mild posterior bulging of the disc in addition to an approximately 0.6 cm right posterior paramedian disc herniation with no evidence of nerve root impingement. The patient underwent neurosurgical evaluation by Dr. on 06/24/09. The patient was noted to be status post physical therapy and facet joint injections without significant improvement. On examination, the patient was noted to have 5/5 motor strength throughout. Deep tendon reflexes were +2 throughout and symmetrical. The patient had no difficulty with toe or heel walking. Tandem walk was within normal limits. Straight leg raising was negative bilaterally. Spurling's sign was negative bilaterally. Sensory exam revealed no hypoesthetic region to pinprick or light touch. Coordination was intact. The patient was determined not to be a surgical candidate at that time.

Independent medical evaluation by Dr. on 11/11/09 reported the patient to have 6 out of 8 positive Waddell's signs significant for symptom magnification. Dr. noted the MRI did not reveal any objective evidence of disc herniation or significant stenosis at any level and only demonstrated pre-existing changes in the facets and the discs. He determined that the effects of the index injury have resolved and that treatment is not medically necessary for the index injury.

The patient subsequently was seen on 05/20/10 by Dr.. The patient stated she was diagnosed as having strain/sprain to the low back. She reportedly had had previous epidural steroid injection which helped her 55% for one week before her pain came back. On examination, there was no perceptible limp in gait. The patient was toe heel able. There was paraspinous muscle tenderness to palpation, midline tenderness and bilateral sciatic tenderness. Gait was slow but no limp was noted. Straight leg raising was normal. Lying down was 65 degrees both sides. Neurologic exam reported movement was physiologic. Sensation was satisfactory. Reflexes were 1-2 at the right knee, 2 on the left. Right ankle was 0-1 and left 1. Muscle strength was satisfactory. Tone was satisfactory. The patient denied bowel or bladder loss of control. The patient was recommended for lumbar transforaminal right sided L5-S1 steroid injection under IV sedation. Utilization review dated 06/07/10 determined that medical necessity was not established as there were no objective findings on examination that would be consistent with solely a right L5 or right S1 radiculopathy. It was noted that without either some type of sensory or motor deficit or some type of positive straight leg raising the diagnosis of radiculopathy is in question and the patient would not qualify for epidural injection at this time.

The patient was seen in follow up on 07/29/10 and complained of really hurting. The patient did not understand why a request for epidural steroid injection had been turned down. Physical examination was essentially unchanged. MRI was again reviewed and noted to show moderate disc desiccation at L5-S1,

mild posterior bulging and a 6 mm right posterior paramedian disc herniation with no evidence of nerve root impingement. The patient was recommended for lumbar ESI at L4-5.

A preauthorization review dated 08/05/10 determined that the request for outpatient interlaminar ESI at L4-5 is not medically necessary. It was noted that the patient had ESIs and selective nerve root blocks in the past with no benefit per the IME report. The IME recommended no further treatment for this x year old injury as well. Also, the MRI pathology was noted to be at right L5-S1, so potentially an L4-5 interlaminar ESI may not be successful either.

An appeal request for interlaminar ESI L4-5 was reviewed on 08/25/10, and determined as not medically necessary. Per the review, the submitted medical record did not satisfy criteria for lumbar epidural steroid injection. In particular, there were inadequate objective findings to satisfy ODG criteria. There was no positive straight leg raising, unequivocal electrodiagnostic evidence of radiculopathy or documented dermatomal distribution of pain, numbness or paresthesias. Therefore, based on ODG treatment index, the proposed epidural steroid injection is not medically necessary. The reason for referral is medical necessity of outpatient interlaminar ESI @ L4-5.

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

Based on the clinical information provided, medical necessity is not established for outpatient interlaminar ESI at L4-5. The patient is noted to have sustained a lifting injury to the low back on xx/xx/xx. MRI revealed a mild posterior disc bulge at L5-S1 with evidence of an approximately 0.6 cm right posterior paramedian disc herniation at this level with no evidence of nerve root impingement. On examination, the patient had no evidence of motor or sensory deficits, and straight leg raising was negative. Moreover, the patient had 6 out of 8 positive Waddell's signs for symptom magnification on independent medical evaluation performed 11/11/09. Given the lack of objective evidence of neurocompressive pathology on imaging studies, and given the absence of radicular findings on clinical examination, outpatient interlaminar ESI at L4-5 is not indicated as medically necessary. Accordingly, the previous denials should be upheld.

Low Back Chapter, Online Version

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. ([Savegh, 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.)

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)