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### Notice of Independent Review Decision

**DATE OF REVIEW:** 01/17/11

**IRO CASE NO.:**

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

Item in dispute: Reconsideration of Forte's NON-AUTHORIZATION of one (1) outpatient right transforaminal epidural steroid injection at the L3-L4 level. Original decision UPHELD.

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

Texas Board Certified Orthopedic Surgeon (Joint)

**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. Clinical records Dr.
2. Clinical records Dr.
3. MRI of the lumbar spine dated 03/16/09
4. MRI of the lumbar spine dated 09/26/10
5. Previous utilization review determination dated 12/16/10
6. Previous utilization review determination dated 12/23/10
7. *Official Disability Guidelines*

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a male who is reported to have sustained work related injuries after lifting 40 lbs. The first available clinic note submitted for review is dated xx/xx/xx. He is reported to have sustained injuries to his low back, neck, hands. At the time of this evaluation he complains of continued neck pain with radiation into upper extremity with

numbness and tingling. On physical examination he has full active range of motion of the cervical spine. No abnormalities are noted. He is opined to have cervical neck herniation. He was to be referred to Dr.. Records indicate the employee made improvement with conservative treatment and was returned to light duty at work. The records suggest he received chiropractic

Treatment and ultimately recommended to undergo MRI of the lumbar spine which was performed on 03/16/09. This study notes mild degenerative changes with disc desiccation at L4-5 and L5-S1 without significant space narrowing. At L4-5 there is a small central annular tear with very small protrusion without significant deformity of the thecal sac or spinal canal stenosis. At L5-S1 there is small left paracentral disc protrusion which very mildly deforms the thecal sac without spinal canal stenosis or neural foraminal narrowing. At T12-L1 there is a very small right posterolateral disc protrusion with very minimal deformity of the thecal sac with no spinal canal stenosis or neural foraminal narrowing.

The employee was initially evaluated by Dr. He reports the employee was diagnosed with cervical HNP and has been treated with physical therapy and medications. His neck pain is reported to have remained constant without change. He reports bilateral arm numbness and tingling along the radial fingers of the left greater than right. He reports low back pain which has been constant and variable. Aggravating conditions include sitting, walking, driving and exercise. Alleviating factors include physical therapy and medications. He further reports left leg numbness and tingling. Current medications include Skelaxin and Vicodin. On physical examination he is reported to be in no apparent distress. He is well developed and well nourished. He has normal range of motion of bilateral shoulders and bilateral hips. On examination of the neck the head moves in smooth coordination with the body motion. He has no tenderness or mass around the cervical paravertebral musculature. He is reported to have decrease in range of motion throughout arc of motion. He has negative cervical compression test, negative Adson's test, negative Spurling's test. On examination of the back there is no lumbosacral tenderness spasticity or bony abnormality. Range of motion does not appear reduced. He has negative provocative testing. Motor strength is 5/5 in both upper and lower extremities. Reflexes are 2/4 and symmetric in upper and lower extremities. He is reported to have positive Tinel's test at wrist bilaterally. Sensory is reported to be intact from L1-S1. Radiographs performed at this visit show small posterior osteophytes at C5-6 and C6-7. Lumbar series reports lateralized facets at L4-5 and L5-S1.

Records indicate the employee was provided oral medications, recommended to perform home exercise program, and was recommended to have a left transforaminal epidural steroid injection at L5-S1. Records indicate the request was not approved on utilization review. Subsequently it went to IRO which upheld the denial. It is reported to have gone to BRC / CCH and was not approved. The clinical records further report that the employee did undergo a cervical epidural steroid injection in 04/09 with reported relief and improvement post procedurally. Records indicate the employee was recommended to undergo MRI of cervical spine which again was not approved under utilization review. Throughout this time period the employee's physical examinations were not indicative of radiculopathy.

On 04/30/10 the employee is reported to have neck and back pain. He is reported to have decreased sensation in the right 2<sup>nd</sup> toe.

On 06/04/10 the employee was seen in follow-up by Dr.. The employee is reported to have cervical spine pain which radiates into bilateral upper extremities. He is noted to have undergone EMG/NCS on 05/25/10 which was reported as normal.

On 06/28/10 the employee was again seen in follow-up by Dr.. He reports he has low back pain causing him significant problems graded 8/10. He reports he can walk up to ½ an hour before he has to stop due to low back pain and left buttock pain. It is reported his Achilles reflexes are diminished compared to Patellar reflexes. Sensation is intact. He is again recommended to undergo lumbar epidural steroid injection.

On 07/26/10 the employee was seen in follow-up. He is reported to have some hyperesthesias along left posterior thigh, but motor function is intact. He has positive straight leg raise and diminished left patellar and Achilles reflexes.

He was again seen in follow-up on 08/25/10 at which time he is reported to have predominately left lower extremity symptoms. He was referred for MRI of lumbar spine on 09/26/10. This study reports normal discs at L1-2 and L2-3. At L3-4 there is osteophytic ridging with 6 mm right foraminal disc protrusion producing mild foraminal stenosis without neural compromise. At L4-5 there is mild osteophytic ridging without focal disc pathology. L5-S1 is reported as normal.

Records indicate on 12/16/10 the request for lumbar epidural steroid injection was reviewed by Dr.. Dr. notes that the employee's radicular symptoms radiated laterally through the left arm to the radial aspect of the forearm with lower extremity tingling and hypersensitivity. He notes a previous denial for a left L4-5 transforaminal epidural steroid injection and that there is a request for epidural steroid injection at L3-4. He notes that the MRI showed a right foraminal disc protrusion producing mild foraminal stenosis. Case does not meet the ODG criteria for radiculopathy for an epidural steroid injection. He notes there must be unequivocal evidence of radiculopathy. He notes that the diagnosis requires a dermatomal distribution, pain, numbness and paresthesias. The retention sign is normally positive and that a herniated disc must be substantiated by an appropriate finding on the imaging study. He notes that the findings on imaging in and of itself do not make the diagnosis of radiculopathy. He reports he does not find dermatomal objective signs on physical examination and therefore denies the request.

On appeal dated 12/13/10 the reviewer notes that the employee's symptoms are reported to be left sided. An MRI scan shows right foraminal disc bulge and stenosis. As such Dr. upholds the previous denial.

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

The request for outpatient right transforaminal epidural steroid injection at the L3-4 level is not supported by the submitted clinical data. The records indicate that the employee has subjective complaints of low back pain with radiation into the left lower extremity. The employee has previously been denied epidural steroid injections at the L4-5 level due to a lack of correlation between imaging studies, subjective complaints and objective findings. The records indicate that the employee underwent MRI of the lumbar spine on 09/26/10 which shows a right sided disc protrusion at the L3-4 level without compression of the exiting nerve roots. The employee's subjective complaints are left sided and non-focal which is inconsistent with the imaging study. Based on the available data presented the determinations by both Dr. and Dr. are appropriate and consistent with the Official Disability Guidelines and therefore these determinations are upheld.

## **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, reduction of medication use 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](#)) Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
- (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 supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular 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.)