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Notice of Independent Review Decision

DATE OF REVIEW: 03/06/12

IRO CASE#:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Open lumbar epidural injection under fluoroscopy to include CPT codes 62311, 77003, 72275, 99144, 99145, A4550, A4649

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

Anesthesiology/Pain Management

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Cover sheet and working documents
2. Employer's first report of injury or illness
3. Exercise/treatment grid dated 05/19/11-06/10/11
4. Handwritten physical therapy daily progress note dated 06/10/11, 06/09/11, 06/07/11, 06/03/11, 06/01/11, 05/31/11, 05/27/11, 05/25/11, 05/23/11, 05/19/11
5. Physical therapy evaluation summary dated 05/16/11
6. Radiographic report dated 03/11/10
7. Progress note dated 06/20/11, 07/08/11, 08/19/11, 11/09/11, 09/27/11, 01/30/12
8. Peer review dated 08/19/11
9. Designated doctor evaluation dated 09/08/11
10. IRO dated 09/25/11
11. Prospective/concurrent review determination dated 08/24/11, 09/02/11, 02/17/12
12. MRI cervical spine dated 06/29/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was walking when she lost her balance and fell backwards. The patient was seen and diagnosed with muscle spasms, cervical spasms, cervical sprain, lumbar pain and lumbar sprain. The patient underwent 10 sessions of physical therapy. Peer review dated 08/19/11 indicates that the compensable injury is a probable cervical sprain and lumbar strain. The 06/20/11 office visit note identified that the claimant had a history of degenerative disc disease and a herniated disc at L5-S1 and surgery had been recommended in 2010. Exam findings available for review did not identify any objective evidence to support any lumbar radiculopathy. Designated doctor exam dated 09/08/11 indicates that diagnosis is degenerative cervical disc disease with a cervical strain and loss of neck motion, but no neurologic involvement. The patient was determined to have reached MMI on 08/08/11 with 5% whole person impairment. Follow up note dated 01/30/12 indicates that the patient complains of pain to the lower back, lower extremities, neck and upper extremities. On physical examination she admits to some numbness and tingling as well as weakness to the right lower extremity all the way down into the toes. There is tenderness across the quadratus lumborum, gluteus maximus and gluteus medius. There is decreased sensation noted with light touch to the right lower extremity all the way down into the toes. Straight leg raises are +40 degrees. Deep tendon reflexes are 2+ bilateral patella, 1+ left Achilles and absent on the right.

Initial request for lumbar epidural steroid injection was non-certified on 02/07/12 noting that the records do not document a consistent presentation among providers of lumbar radiculopathy. Designated doctor placed the patient at MMI IR 5% with no rating for the lumbar region. There are no lumbar imaging reports provided. The denial was upheld on appeal dated 02/17/12 noting that records provided detail that the claimant has a known history of pre-existing back issues and was previously diagnosed with a herniated lumbar disc. Neither the peer review nor the DDE on the file establish the presence of a verified lumbar radiculopathy as caused by the work incident. No basis to alter or amend previous prior adverse determination.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL:

Based on the clinical information provided, the request for open lumbar epidural injection under fluoroscopy to include CPT codes 62311 77003 72275 99144 99145 A4550 A4649 is not recommended as medically necessary. The patient's physical examination fails to establish the presence of active lumbar radiculopathy, and there are no imaging studies/electrodiagnostic results provided to support the diagnosis as required by the **Official Disability Guidelines**. The patient was determined to have reached maximum medical improvement as of 08/08/11 with whole person impairment by a designated doctor. Peer review dated 08/19/11 indicates that the compensable injury is a probable cervical sprain and lumbar strain, noting that exam findings available for review did not identify any objective evidence to support any lumbar radiculopathy.

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

BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE	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. <i>Short-term symptoms:</i> The American Academy of Neurology recently concluded that epidural
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DECISION: ODG**Low Back****Chapter** Epidural steroid injections (ESIs), therapeutic

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](#)) A recent RCT of 29 patients divided into three groups addressed the use of ESIs for treatment of spinal stenosis. A control group with no treatment was compared to a group receiving passive physical therapy for two weeks and another receiving an interlaminar ESI at the stenotic level. At two weeks the group that received the ESI had significantly better pain relief than the other two groups. When the three groups were compared there was no statistical difference except in pain intensity and Roland Morris Disability Index and this was at two weeks only. The authors stated that improvement only appeared to be in the early phase of treatment. ([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](#)) Two recent RCTs of caudal injections had different conclusions. This study concluded that caudal injections demonstrated 50% pain relief in 70% of the patients, but required an average of 3-4 procedures per year. ([Manchikanti, 2011](#)) This higher quality study concluded that caudal injections are not recommended for chronic lumbar radiculopathy. ([Iversen, 2011](#))

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. ([Deyo, 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](#)) ESIs are more often successful in patients without significant compression of the nerve root and, therefore, in whom an inflammatory basis for radicular pain is most likely. In such patients, a success rate of 75% renders ESI an attractive temporary alternative to surgery, but in patients with significant compression of the nerve root, the likelihood of benefiting from ESI is low (26%). This success rate may be no more than that of a placebo effect, and surgery may be a more appropriate consideration. ([Ghahreman, 2011](#)) According to this RCT, the use of MRI before ESIs does not improve patient outcomes and has a minimal effect on decision making, but the use of MRI might have reduced the total number of injections required and may have improved outcomes in a subset of patients. Given these potential benefits as well as concerns related to missing important rare contraindications to epidural steroid injection, plus the small benefits of ESIs themselves, ODG continues to recommend that radiculopathy be corroborated by imaging studies and/or electrodiagnostic testing. ([Cohen, 2012](#))

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. 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.)