



**MEDICAL EVALUATORS
OF TEXAS ASO,LLC.**

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800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

March 6, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar ESI at right L5-S1 62311, 77003, J3301, J2250, 01992

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

This case was reviewed by a physician who holds a board certification in Physical Medicine and Rehabilitation and is currently licensed and practicing in the state of Texas. The reviewer is considered to be an expert in their field of specialty with current hands on experience in the denied coverage.

REVIEW OUTCOME

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

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx to his lower back due to lifting. He was diagnosed with displacement of lumbar intervertebral disc without myelopathy, thoracic or lumbosacral neuritis or radiculitis, and unspecified lumbar sprain. He has been treated conservatively with medications, physical therapy and nerve blocks. His medication history included Norco, Robaxin, Lyrica and Naproxen 500mg. He had MRI of the lumbar spine on 09/13/2012 that showed multilevel thoracolumbar spine discogenic degenerative changes. At L5-S1, minimal central disc protrusion is observed along with small right paracentral annular fissure. There was no central spinal stenosis. Mild ligamentum flavum and facet hypertrophic changes were identified. Neural foraminal showed mild bilateral foraminal narrowing. EMG/NCS of lower extremities done on 04/04/2013 showed limited findings suggestive of a right S1



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radiculopathy. A repeat EMG/NCS on 04/03/2014 showed electrophysiological evidence of a left S1 radiculopathy.

Office visit on 12/11/2014 indicates the patient complained of low back pain radiating into the right lower extremity. The pain was described as sharp, shooting, aching and throbbing in nature. Pain level was 4-6/10 at best and pain level at the worst was 7-9/10. Treatment tried includes physical therapy multiple sessions with minimal to no relief and pain was made better by nerve blocks. Objective findings during lumbar examination revealed poor toe walking and poor heel walking. Diminished deep tendon reflexes in the right lower extremity. Straight leg raise was positive on the right. Diagnoses were lumbar strain, lumbar herniated nucleus pulposus, and lumbar radiculopathy. Plan was diagnostic ESI at L5-S1 level on the right.

Office visit on 02/12/2015 indicates the patient complained of low back pain radiating into the right lower extremity. Pain level was 0-3/10 at best and 7-9/10 at worst. The patient reported medication helps. Objectively, no significant changes in the physical exam since the last office visit. Treatment recommended was ESI at L5-S1 level on the right.

The request for Lumbar ESI at right L5-S1 was denied because there was a lack of documentation in regards to percentage of pain relief from the previous block. Additionally, there was a lack of documentation in regard continued objective documented pain relief, decreased need for pain medications, and functional response from the previous block. Therefore, the medical necessity has not been established.

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

As per the ODG, ESI is recommended if after the initial block/blocks are given and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. In this case, this patient reported lower back pain radiating into right lower extremity. Treatment tried includes medications, physical therapy and nerve blocks. However, there is no documentation that the prior blocks resulted in 50-70% pain relief for at least 6-8 weeks.

Further ODG recommends, "objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing." In this case, the findings of EMG/NCS are inconsistent with radiculopathy. The EMG done on 04/04/2013 showed right S1 radiculopathy but a repeat EMG/NCS done on 04/03/2014 showed left S1 radiculopathy. His physical exam is also limited and not specific for right S1 radiculopathy. Therefore, based on the records provided,



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the request for right L5-S1 epidural steroid injection is not reasonable and medically indicated.

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)

**ODG, Chapter - Low Back – Lumbar and Thoracic (Acute and Chronic)
Epidural Steroid Injections (ESI)**

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. Not recommended for spinal stenosis or for nonspecific low back pain. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, but ESIs have not been found to be as beneficial a treatment for the latter condition. According to SPORT, ESIs are associated with less improvement in spinal stenosis. ([Radcliff, 2013](#))



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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](#))

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.

For spinal stenosis: The use of epidural steroid injection (ESI) in patients with lumbar spinal stenosis is common, but there is little evidence in the literature to demonstrate its long-term benefit. Despite equivalent baseline status, ESIs are associated with significantly less improvement at 4 years among all patients with spinal stenosis. Furthermore, ESIs were associated with longer duration of surgery and longer hospital stay. There was no improvement in outcome with ESI whether patients were treated surgically or nonsurgically. There was no distinct surgical avoidance noted with ESI. ([Radcliff, 2013](#)) This systematic review found the data was limited to suggest that ESI is effective in lumbar spinal stenosis. ([Bresnahan, 2013](#)) An RCT addressed the use of ESIs for treatment of spinal stenosis, and there was no statistical difference except in pain intensity and Roland Morris Disability Index and this was at two weeks only. ([Koc, 2009](#)) According to the APS/ ACP guidelines, ESIs are not for nonspecific low back pain or spinal stenosis. ([Chou, 2008](#)) According to a high quality RCT, in the treatment of symptoms of lumbar spinal stenosis, epidural injections of glucocorticoids plus lidocaine offered minimal or no benefit over epidural injections of lidocaine alone at 6 weeks. At 3 weeks, the glucocorticoid-lidocaine group had greater improvement than the lidocaine-alone group, but the differences were clinically insignificant. Despite a rapid increase in the use of epidural glucocorticoid injections for lumbar spinal stenosis, there is little evidence of effectiveness from clinical trials. ([Friedly, 2014](#))

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



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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](#)) Transforaminal epidural steroid injections, despite being generally regarded as superior to interlaminar injections, are not significantly better in providing pain relief or functional improvement, according to a new systematic review. ([Chien, 2014](#))

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](#)) Not recommended post-op. The evidence for ESI for post lumbar surgery syndrome is poor. ([Manchikanti, 2012](#))

Patient selection: Radiculopathy must be documented, as indicated in the ODG criteria. In addition, 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](#)) Injections for spinal pain have high failure rates, emphasizing the importance of patient selection. Individuals with centralized pain, such as those with fibromyalgia and chronic



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widespread pain, and poorly controlled depression, may be poor candidates. ([Brummett, 2013](#))

MRIs: 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](#))

Fracture risk: Lumbar ESIs are associated with an increased risk for spinal fracture. Each single additional ESI increased the risk for fracture by 21%, with an increasing number of ESIs associated with an increasing likelihood of fracture. Use of ESIs seems to promote deterioration of skeletal quality. This definable fracture risk should be balanced with the best available evidence regarding the long-term efficacy of ESIs, which is limited. Clinicians should consider these findings before prescribing ESIs for elderly patients. ([Mandel, 2013](#))

Recent research: 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](#)) In this RCT there were no statistically significant differences between any of the three groups at any time points. This study had some limitations: only one type of steroid in one dose was tested; the approach used was caudal and transforaminal injections might provide superior results. ([Weiner, 2012](#)) Effects are short-term and minimal. At follow-up of up to 3 months, epidural steroids were associated with statistically significant reductions in mean leg pain and mean disability score, but neither of these short-term improvements reached the threshold for clinical significance. There were no significant differences in either leg pain or disability at 12 months follow-up. ([Pinto, 2012](#)) According to this systematic review, ESIs without the drug (epidural nonsteroid injections), often used as a placebo treatment, were as effective as ESIs and better than no epidural injections. ([Bicket, 2013](#)) This meta-analysis suggested that ESI did not improve back-specific disability more than a placebo or other procedure long-term (6 months), and did not significantly decrease the number of patients who underwent subsequent surgery. ([Choi, 2013](#)) The FDA is warning that injection of corticosteroids into the epidural space of the spine may result in rare but serious adverse events, including loss of vision, stroke, paralysis, and death. ([FDA, 2014](#)) This study shows that ESIs had a significant beneficial effect as an additional treatment for lumbosacral radicular syndrome in general practice, but the effect was too small to be considered clinically relevant to patients, so the authors



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do not recommend ESIs as a regular intervention in general practice. ([Spijker-Huiges, 2014](#))

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 (due to herniated nucleus pulposus, but not spinal stenosis) 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.)