



**363 N. Sam Houston Pkwy E.  
Suite#1100  
Houston, TX 77060  
281-931-1201**

## **IRO REVIEWER REPORT**

**March 12, 2018**

**IRO CASE #: XXXXXX**

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

Denial of Epidural Steroid Injection T9-T10

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

This case was reviewed by a Board-certified Orthopedic Surgeon who 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:

**X Overturned (Disagree)**

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a XX who sustained injury to XX upper back on XXXX. XX was diagnosed initially with thoracic sprain/strain. XX was treated with an extensive course of conservative treatments including physical therapy, home exercise program, Tylenol, and tramadol but his symptoms persisted. XX had MRI of the thoracic spine on XXXX that showed small posterior disc bulge at T9-10 on left, no spinal stenosis, subtle foraminal encroachment bilaterally at T9-10.

Clinic visit dated XXXX by Dr. XX indicates the patient complained of continued upper back pain between XX shoulder blades 6/10. Pain was aching in nature. XX had done formal PT and taken Tylenol but still reported pain and difficulty with ADLs. Exam was reported as thoracic spine tenderness to palpation, decreased range of motion, no weakness, spasm and tenderness to palpation on the left. Repeat clinic visits dated XXXX and XXXX revealed the patient continued subjective complaints and no change in objective findings. Clinic visit dated XXXX indicated the patient reported continued pain. Dr. XX reported back pain with "radiation in a radicular pattern". Exam was unchanged. ESI at T9-10 was recommended to avoid potential surgery.

Designated doctor exam dated XXXX by Dr. XX concluded that the compensable injury included T9-10 disc herniation but not thoracic radiculopathy. Second DD exam by Dr. XX, ortho, dated XXXX indicates the exam consistent with tenderness to palpation at T9-10 with spasms on left, normal neurological exam, decreased thoracic range of motion, and normal strength. XX was found to be at MMI on XXXX with 5% WP IR for thoracic sprain/strain. Dr. XX concluded that compensable injury included both T9-10 disc herniation AND thoracic radiculopathy and placed not at MMI

Clinic visit dated XXXX indicates the patient followed up for mid back pain. The patient reported symptoms have gradually gotten worse. XX denied bowel or bladder dysfunction. XX denied any saddle paresthesia. XX denied any significant motor weakness/paralysis. Thoracolumbar spine exam showed thoracic spine spasms of bilateral paraspinal muscles. Thoracolumbar spine pain elicited by rotation to right. Thoracolumbar spine pain elicited by rotation to left. Thoracolumbar spine pain elicited by lateral flexion to the right. Thoracolumbar spine pain elicited by lateral flexion to left. No full range of motion of thoracolumbar spine. Thoracolumbar spine flexion abnormal. Thoracolumbar spine extension abnormal. Strength was normal in lower extremities. Sensation exam was normal. Deep tendon reflexes normal.

Court decision XX dated XXXX considered input from both DD exam by Dr. XX and Dr. XX, but ruled that in line with Dr. XX given XX credentials and argument. Compensable injury was ruled to included both T9-10-disc herniation and thoracic radiculopathy. This case has undergone numerous previous adverse determinations most recently by Drs. XX on XXXX and Dr. XX on XXXX.

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

According to ODG, the criteria for the use of the epidural steroid injection includes radiculopathy must be documented. Objective findings on exam need to be present. Radiculopathy must be corroborated by imaging studies and/or EMG. Condition must be unresponsive to conservative treatments such as exercise, PT, NSAIDs, or muscle relaxants. Injection should be performed using fluoroscopy. In this case, the main issue is whether the patient has objective findings of radiculopathy associated with the known disc herniation at T9-10. The stance taken by the reviewers of the previous adverse determinations was that objective evidence was not sufficiently presented to warrant approval. In contrast with the lumbar spine, radicular findings in the thoracic spine are much more subtle and are, in many instances, a diagnosis of exclusion after other causes have been ruled out. As such, there will be no corresponding motor weakness or change in reflexes that typically occurs in the lumbar spine. The clinical presentation is typically that of a band of pain, paresthesia, etc at that dermatomal distribution (Yabe et al, Choi et al, O'Connor et al, Ulrich et al). The clinical documentation for this case clearly includes a persistence of pain, spasm, and tenderness to palpation at the it's a encroachment" at that level which meets imaging criteria. The patient has failed numerous conservative modalities, and the treating provider has recommended ESI in order to avoid potential surgical intervention. The findings of Dr. XX examination and the decision by the XX have both concluded that the disc herniation and thoracic radiculopathy are part of the compensable injury. Given these findings, the persistence of clinical symptoms including pain, spasm, and tenderness at the proposed level, the lack of formal ODG guidelines for thoracic disc herniation, and the known diagnostic difficulty in identifying radiculopathy in the thoracic spine, there is sufficient evidence that this represents a radiculopathy. Therefore, it is the opinion of this reviewer that the medical necessity has been established for the request of epidural steroid injection at T9-T10. Thus, the previous adverse determination is overturned.

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

Ulrich CT1, Fung C1, Piechowiak E2, Gralla J2, Raabe A1, Beck J3. Disc herniation, occult on preoperative imaging but visualized microsurgically, as the cause of idiopathic thoracic spinal cord herniation. *Acta Neurochir (Wien)*. 2018 Mar;160(3):467-470. doi: 10.1007/s00701-018-3466-3. Epub 2018 Jan 19.

Choi HE1, Shin MH1, Jo GY1, Kim JY2. Thoracic Radiculopathy due to Rare Causes. *Ann Rehabil Med*. 2016 Jun;40(3):534-9. doi: 10.5535/arm.2016.40.3.534. Epub 2016 Jun 29.

Yabe Y1, Honda M, Hagiwara Y, Tohjo Y, Nakajima S, Ando A, Sonofuchi K, Itoi E. Thoracic radiculopathy caused by ossification of the ligamentum flavum. *Ups J Med Sci*. 2013 Mar;118(1):54-8. doi: 10.3109/03009734.2012.715598. Epub 2012 Nov 20.

O'Connor RC1, Andary MT, Russo RB, DeLano M. Thoracic radiculopathy. *Phys Med Rehabil Clin N Am*. 2002 Aug;13(3):623-44, viii.

## **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES - Online Version**

### **Low Back - Lumbar and Thoracic (Acute and Chronic) - (updated 12/28/17)**

#### **Epidural steroid injections (ESIs), therapeutic**

#### **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, the reduction of medication use and the avoidance of 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, muscle relaxants, and neuropathic drugs).
- (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.)
- (12) Excessive sedation should be avoided.