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Notice of Independent Review Decision

DATE OF REVIEW: 05/23/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Item in dispute: Caudal epidural steroid block under fluoroscopy

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

Board Certified Orthopedic Surgeon
Texas Medical License

REVIEW OUTCOME

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

Denial Upheld

Caudal epidural steroid block under fluoroscopy is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The employee is a male who was reported to have sustained multiple injuries. The first report of injury indicated that the employee slipped while loading a battery into a forklift.

Records indicate that the employee was evaluated at the Medical Center on 11/15/98. Radiographs were performed of the cervical and lumbar spine. The radiographic reports indicated evidence of degenerative disc disease at the C5-C6 level with no other acute bony abnormalities seen within the cervical spine. In regard to the lumbar spine, there were mild degenerative changes at L3-L4 and L4-L5. There was mild spurring noted at the L3 level without significant disc space narrowing. There were no pars defects seen on oblique views. No other bony abnormality was identified in the lumbar spine.

Records indicate that the employee subsequently received chiropractic treatments from D.C. and D.C.

On 11/24/98, the employee was subsequently referred to Dr. for evaluation. The employee was reported to have been experiencing some neck and low back pain since a work related injury on xx/xx/xx. He was changing a battery and slipped on some oil falling to the ground. He had the immediate onset of back and neck pain but finished the workday.

The employee continued to experience pain through the evening, and the next morning was seen at the emergency room where he was evaluated, medicated, and subsequently released.

The employee was reported to have continued symptoms and sought treatment from D.C., and began to have chiropractic therapy and physical therapy. The employee was reported to have obtained some improvement with this treatment, but his symptoms persisted. It was reported that the employee had an old back injury in xxxx and was treated conservatively and improved. On physical examination, the patellar and Achilles reflexes were diminished on the left when compared to the right. The EHL had equal strength bilaterally. Lasegue's straight leg test was positive bilaterally. Patrick-Fabere's test was positive bilaterally. Ely's heel to buttocks test was positive bilaterally. Hip hyperextension was positive bilaterally. There were no sensory deficits of the lower extremities. Quadriceps strength was equal bilaterally. He ambulated without assistance; however, he moved slowly on the examination table. He had restricted range of motion of the cervical spine and lumbar spine. Upper extremity reflexes were equal and physiologic. Strength was reported to be intact. There were no pinprick deficits in the upper extremities. The employee was diagnosed with acute cervical, dorsal and lumbar strains, and left sciatic radiculitis. The employee was recommended to continue in physical therapy. He was referred for MRI of the cervical and lumbar spines.

The employee was seen in follow up on 04/13/99. He was reported not to have improved with continued conservative care. His physical examination remained unchanged. Dr. recommended manipulation under anesthesia with
lumbar epidural steroid injections. He reported that an MRI revealed some small disc changes at L4-L5 and L5-S1.

On 05/13/99, the employee underwent a lumbar epidural steroid injection at L5-S1.

When seen in follow up on 05/21/99, the employee reported that his back pain was much improved since his last visit. He obtained good relief with manipulations followed by injections. On physical examination, his upper and lower extremities reflexes were symmetric and intact. His upper and lower extremity strength was symmetric and intact bilaterally. There was no neural sensory deficit of the upper or lower extremities. He had some restricted range

of motion of the cervical and lumbar spines with discomfort at the extremes. The employee was recommended to continue physical therapy and complete a series of epidural steroid injections.

The employee underwent a second lumbar epidural steroid injection on 06/25/99.

The employee was seen in follow up on 07/13/99. It was reported that his neck pain was improved; however, his low back pain had seemed to worsen. He had participated in physical therapy and was taking medications. He had numbness in the legs without radicular pain. The employee's physical examination was largely unchanged. It was recommended that he continue with physical therapy and a work hardening program. He was provided oral medications and recommended to have a third lumbar epidural steroid injection.

On 08/20/99, the employee underwent a third lumbar epidural steroid injection.

The employee was subsequently seen in follow up on 10/28/99. His low back and right leg pain was reported to have persisted but improved. The employee was now recommended to have a psychological evaluation and continue conservative care. An MRI of the lumbar spine was performed on 01/08/99. This study reported a 2 mm posterior disc bulge which indented the anterior thecal sac and caused narrowing of the neural foramina at L4-L5. At L5-S1, there was a 1 mm posterior disc bulge, and no foraminal stenosis or narrowing of central spinal canal. The discs were desiccated at L4-L5 and L5-S1.

On 01/20/00, the employee was placed at Maximum Medical Improvement (MMI) by his treating provider, D.C. He was reported to have a 15% whole person impairment. He was reported to have a 10% impairment for range of motion of the cervical spine and 5% impairment for specific disorders due to lumbar disc protrusion.

On 04/05/00, the employee was seen by Dr. Dr. noted the above history. He indicated that the employee had been treated conservatively with medication and chiropractic care for the last two years with minimal resolution of his pain. He had received three epidural steroid injections which did not alleviate his pain. Continued chiropractic treatment had not resolved his pain. Dr. recommended that the employee undergo three level discography at L3-L4, L4-L5, and L5-S1.

The employee subsequently underwent this procedure on 05/05/00. L3-L4 was reported to not have any concordant pain. L4-L5 also showed no concordant pain. At L5-S1, it was reported that the employee had concordant pain.

Records indicate that the employee appears to have undergone a selective nerve root block on 06/30/00. Records indicate that the employee was later suggested to undergo an IDET procedure.

A CT of the lumbar spine was performed on 06/02/00. This study was reported to demonstrate a left central paracentral disc bulge at L4-L5 of approximately 6-7 mm. There was a minimal central bulge of approximately 2 mm seen at L5-S1 with no extravasation of contrast.

Records indicate that the employee was later offered surgery, where it was recommended that he undergo posterior L5-S1 discectomy with PLIF. The second and third opinions regarding surgery were not strongly in favor. It was recommended that the employee undergo additional diagnostic studies given that there was no convincing evidence of what the actual pain generator was.

On 11/20/01, Dr. reported that a repeat MRI was performed which revealed disc desiccation and bulging at L4-L5 and L5-S1. Dr. did not completely concur that a repeat lumbar discogram was medically necessary, noting that the employee was reported to have concordant pain at L5-S1 and extravasation of contrast at L4-L5. The employee was subsequently recommended to participate in the PRIDE program.

On 08/28/02, the employee was reported to have L4-L5 discogenic pain with a herniated disc and intractable low back pain. The employee underwent a morphine pump trial via intrathecal injection of Duramorph. Post procedurally the employee reported no pain. The employee apparently required psychiatric counseling due to severe depression.

On 04/11/03, the employee underwent a trial of spinal cord stimulation. He was reported to have good results with a dual lead spinal cord stimulator at T8-T9. He was reported to have 100% relief of his pain for the first day. The employee's lead shifted; however, he was getting 70% pain relief.

The employee was subsequently taken to surgery on 05/02/03 and_underwent the permanent implantation of a spinal cord stimulator. Records indicate that the employee subsequently returned to work on 07/2003 with progressively decreasing work restrictions. The employee continued to receive pain management from Dr..

The employee was later reported to have developed bilateral sacroiliitis and underwent right sacroiliac injections on 11/18/05.

On 01/11/06, the employee underwent bilateral L3, L4, L5, S1, S2, and S3 median branch nerve blocks.

The employee was subsequently recommended for and underwent radiofrequency ablation of the medial branch nerves on the right at L3, L4, L5, S1, S2, and S3 on 03/17/06.

On 04/04/06, the employee was reported to be status post radiofrequency ablation of the right L3, L4, L5, S1, S2, and S3 median branch nerves on

03/17/06. Post procedurally, his pain score was 6/10. Since the procedure, he reported constant pain in the low back at L4-L5 and L5-S1. He stated that the pain down his right leg had decreased somewhat.

Records indicate that the employee was seen by the pain management physicians. His spinal cord stimulator was tested and was apparently inoperative.

A CT of the lumbar spine was performed on 02/08/08. This study reported a broad-based disc protrusion measuring fewer than 4 mm at L5-S1. The disc was calcified and lies predominantly within the anterior epidural space without displacement of the S1 neural elements. There was moderately severe neural foraminal narrowing left greater than right due to an accentuation of the disc beyond both neural foramina, as well as facet hypertrophy.

The employee was subsequently referred to Dr. on 03/14/08. Dr. noted the extensive history above. He reported it had been three years since the employee's last interventional block, and he would like to repeat a high volume single caudal epidural steroid block to determine if he obtained a like response. The employee's physical examination at that time indicated he flexed to 90 degrees without difficulty and had mild discomfort. Lateral bending revealed paraspinal muscle guarding bilaterally left greater than right. Extension and rotation were painful in the low back. There was tenderness over his lumbar paraspinal musculature bilaterally. Deep tendon reflexes were intact. Straight leg raise was reported to be positive bilaterally. Motor strength was graded as 5/5 in the EHL.

A request was submitted on 03/24/08 for high volume caudal epidural steroid injection. This was reviewed by Dr.. Dr. provided an adverse determination. She reported it was over nine years from the date of injury. The employee was status post exhaustive treatment to include multiple spinal injections. A clinical note dated 03/14/08 documented no lasting benefit from prior injections, and no objective evidence of radiculopathy.

This was subsequently submitted for reconsideration on 03/28/08. The case was reviewed by Dr. Dr. noncertified the request and reported the employee had received epidural steroid injections in the past with inadequate response, and on examination, the employee did not have objective signs of radiculopathy. He reported ***Official Disability Guidelines*** criteria for lumbar epidural steroid injections was unmet.

The most recent clinical record is dated 05/09/08. Dr. again requested caudal epidural steroid injection. Dr. opined that the employee would be entitled to a diagnostic epidural steroid injection.

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

I would concur with the two previous reviewers that caudal epidural steroid injection is not indicated and not supported by current evidence-based guidelines. The available medical records indicate that the employee has had longstanding intractable low back pain. The employee has undergone multiple diagnostic tests with no clear isolation of the pain generator in the lumbar spine. The employee has undergone multiple interventional procedures, which have included epidural steroid injections, medial branch blocks, radiofrequency ablation, and bilateral sacroiliac joint injections with no sustained response. The previous records fail to appropriately identify the percentage of relief that the employee received; however, the employee continued to receive interventional procedures.

The employee has recently come under the care of Dr. who has subsequently recommended that the employee undergo caudal epidural steroid injection. Dr. has utilized the criteria for a diagnostic block to support his request for this procedure. In fact the employee has undergone multiple epidural steroid injections, and the utilization of a diagnostic block would not be appropriate or medically necessary.

Official Disability Guidelines require that for a employee to receive therapeutic blocks, efficacy of the procedure must be established. In that the records do not document any significant or sustained response, further blocks would not be warranted either under ***Official Disability Guidelines*** or ASIPP guidelines. Additionally, the employee's physical examination does not establish the presence of an active lumbar radiculopathy, again which would not support the performance of caudal epidural steroid injection. Additionally it was noted that the employee has undergone implantation of a spinal cord stimulator which is currently not functional. The spinal cord stimulator appears to have provided coverage for the employee's subjective complaints very effectively in the past.

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

1. The ***Official Disability Guidelines***, 11th Edition, The Work Loss Data Institute.
2. Laxmaiah Manchikanti, MD, Vijay Singh, MD, David Kloth, MD, Curtis W. Slipman, MD, Joseph F. Jasper, MD, Andrea M. Trescot, MD, Kenneth G. Varley, MD, Sairam L. Atluri, MD, Carlos Giron, MD, Mary Jo Curran, MD, Jose Rivera, MD, A. Ghafoor Baha, MD, Cyrus E. Bakhit, MD and Merrill W. Reuter, MD. ***American Society of Interventional Pain Physicians Practice Guidelines***. *Pain Physician*, Volume 4, Number 1, pp 24-98, 2001.