



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

Notice of Independent Review Decision-WC

**DATE OF REVIEW: 8-5-09**

**IRO CASE #:**

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

Repeat MRI of the lumbar spine and repeat caudal epidural steroid injection

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

American Board of Orthopaedic Surgery-Board Certified

**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)

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**

- Records from DC.
- Records from MD.
- Records from MD.
- Records from DC.
- Records from MD.
- Records from MD.
- Records from DO.

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

Medical records reflect the claimant presented for treatment under the direction of DC., on 4-3-08. The claimant complains of significant back pain and right knee pain. The claimant was started with a course of physical medicine modalities and procedures.

MRI of the lumbar spine dated 4-14-08 shows at L5-S1 central disc extrusion and diffuse disc bulge and degenerative changes with moderate spinal canal stenosis and moderate to severe bilateral neural foraminal stenosis. The disc extrusion may contact the bilateral S1 nerve roots in the lateral recesses. At L4-L5, there is diffuse disc bulge and degenerative changes with mild thecal sac stenosis and moderate bilateral neural foraminal stenosis. There is mild L3-L4 diffuse disc bulge and degenerative changes with mild bilateral neural foraminal stenosis. At L2-L3, there is posterior annular disc bulge. There are multilevel degenerative changes of the lumbar spine, most pronounced at L5-S1 level. Small 4 mm synovial cyst posterior to the right L4-L5 articular facet joint.

MRI of the right knee shows small knee joint effusion and mild subcutaneous edema, proximal MCL strain. Small 1.5 cm focus of marrow edema involving the anterior medial femoral condyle, likely sequelae of DJD versus osseous contusion, stress injury or hyperemia. Mild chondromalacia of the patellofemoral compartment. Small osteochondral defect versus subchondral cyst involving the posterior proximal tibia.

On 4-28-08, MD., reports the claimant sustained a work injury on xx/xx/xx. On this date, he was walking out of the back of his truck pushing containers when a co worker hit the button to the tailgate lift lowering it, then the claimant stumbled out of a truck and rolled about 4 feet. The claimant complains of low back pain and right leg pain. On exam, the claimant has DTR brisk at the knees and intact at the ankle. SLR is positive on the left with pain in the ipsilateral low back and buttocks. Lasaegue is negative. Motor strength is 5/5. There is tenderness bilaterally at the lower back. The evaluator recommended a high volume caudal epidural steroid injection.

On 5-12-08, the claimant underwent caudal epidural steroid injection.

Electrodiagnostic testing of the lower extremities dated 5-2-08 shows suggestion of bilateral L5 and S1 radiculopathy.

On 6-23-08, Dr. reported the claimant is status post caudal epidural steroid injection performed on 5-12-08. The evaluator noted that the pain was ablated post the injection for a couple of days and then returned just below the baseline. The claimant continues to report low back pain. Post the injection, the claimant underwent six sessions of therapy with Dr. and it felt that it was more beneficial for the low back than for the leg. His medications continued to remain unchanged. He is on Hydrocodone, Skelaxin and Motrin. On exam, the claimant has paraspinal spasms bilaterally, left greater than right. There is no tenderness present. Reflexes are brisk at the knees and intact at the ankle. SLR is positive on the left. Lasaegue remains negative. Motor strength is 5/5. The evaluator recommended repeating the caudal epidural steroid injection.

On 6-26-08, MD., performed a Peer Review. It was his opinion that the evaluator noted that the knee injury was not acute. As it related to the lumbar spine, the claimant has multiple level degenerative changes and annular findings. There is an acute disc herniation and the literature would support that the herniation is a function of degeneration and not the acute event. The evaluator recommended home exercise program, non-steroidal anti-inflammatory medications. Surgery is not necessary. The knee changes are degenerative changes.

Medical records reflect the claimant received treatment under the direction of for the right knee injury.

Peer Review performed by DC., dated 7-7-08 shows that the request for continuing active rehab 3 x 4 to the knee is not medically necessary.

Follow-up visit with Dr. dated 7-21-08 notes the claimant has not taken any medications since the injection. The evaluator recommended a work hardening program and the claimant was provided with information for DARS.

On 4-3-09, DC., performed a Treating Doctor Evaluation. He certified the claimant had not reached MMI and estimated 10-1-09 as the date of MMI. The evaluator recommended referral to Dr. for the knee to see if he feels that the claimant needs an

arthroscopy. The evaluator also recommended the claimant follow-up with Dr. He has had two epidural steroid injections in his low back and has had no improvement.

On 4-13-09, the claimant was evaluated by MD. It is noted the claimant complains of continued low back pain and the return of his right knee pain. The claimant continues to see Dr. for the right knee. The claimant reports he has undergone work hardening, but has been told he is unable to return to work at this time. The claimant's medications include Ibuprofen, Tramadol, and Skelaxin. The claimant reports that the medications are very helpful. On exam, the claimant has paraspinal spasms on the right, extension and rotation is positive bilaterally, right more than left with pain in the low back. There is tenderness bilaterally, left more than right. SLR is positive bilaterally, right more than left with pain in the lower back. Lasegue is positive on the right with pain in the low back. Motor strength is 5/5. The evaluator alerted the claimant regarding his high blood pressure. The evaluator recommended repeating caudal epidural steroid injection and repeating MRI, as the first one was two weeks post the date of injury and one year ago. The claimant is considered a surgical candidate.

On 4-7-09, MD., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated 7-7-09 as the date of MMI. The evaluator recommended a discogram of the lumbar disc.

A Peer Review dated 5-14-09 performed by MD., notes non-certification for the repeat MRI of the lumbar spine. There does not appear to be any new neurologic findings or progressive neurologic loss. Regarding the epidural steroid injection request, the evaluator reported that there are no objective signs of radiculopathy with reflex, motor or sensory changes on exam. Therefore, the criteria for an epidural steroid injection are not met.

A Peer Review dated 5-27-09 performed by DO., notes the requested caudal epidural steroid injection and repeat MRI of the lumbar spine are not medically necessary. The evaluator reported the claimant had good results from the previous second epidural steroid injection. The evaluator recommended only one transforaminal epidural steroid injection. There are no indications for repeat MRI. Neurological exam has not changed.

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

MEDICAL RECORDS REFLECT A CLAIMANT WITH COMPLAINTS OF LOW BACK PAIN. THE CLAIMANT HAS BEEN TREATED WITH MEDICATIONS, CHIROPRACTIC THERAPY, AND TWO EPIDURAL STEROID INJECTIONS WITH REPORTED LIMITED PAIN RELIEF. MEDICAL RECORDS REFLECT NO CHANGES IN NEUROLOGICAL STATUS OR NEUROLOGICAL EXAMINATION. THEREFORE, THERE IS NO INDICATION FOR A REPEAT MRI OF THE LUMBAR SPINE.

AS IT RELATES TO A CAUDAL EPIDURAL STEROID INJECTION, IT IS NOTED THE CLAIMANT HAS FAILED THIS FORM OF TREATMENT IN THE PAST. THEREFORE, I SEE NO INDICATION FOR REPEATING THIS FORM OF TREATMENT.

## **ODG-TWC, last update 7-28-09 Occupational Disorders of the Low Back – MRI and epidural steroid injection:**

### **Indications for imaging -- Magnetic resonance imaging:**

- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)
- Uncomplicated low back pain, suspicion of cancer, infection
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, stepwise progressive
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient

### **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, 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)

(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 required. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of 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.)

**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)**