

## Notice of Independent Review Decision

**DATE OF REVIEW:** SEPTEMBER 3, 2010

**IRO CASE #:**

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

Lumbar Caudal Epidural Steroid Injection (done through catheter under fluoro scopy with IV sedation).

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

This reviewer is Board Certified in Physical Medicine and Rehabilitation with 14 years of clinical experience.

**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**

On June 13, 2002, Lumbar Myelogram and Post-Myelogram Lumbar CT was performed. Findings: The examinee has five fully segmented lumbar vertebrae. The vertebral bodies are of normal height and they are normally aligned. There is mild to moderate disc space narrowing at L4-5. There is spurring of the superior plates of L3, L4, and L5. There is an anterior extradural defect at L4-5. There is mild narrowing of the transverse diameter of the spinal canal at L4-5. The L4 and L5 nerve root sleeves are not well opacified. The conus is normal in appearance. There is also very minor anterior extradural defect at L2-3 when the examinee is in the upright fully extended position. L2-L3: Although there is a mild anterior extradural defect seen on the myelogram with the examinee in the supine position, no evidence of significant posterior disc bulge is identified. There is anterior hypertrophic spurring at this level. The neural foramina and spinal canal are of adequate caliber. The facet joints are normal. Conclusions: Broad-based, posterior disc bulge, L4-5, produces mild spinal stenosis and displaces both L5 nerve roots. There is also marked anterior hypertrophic spurring at this level. Left paramedian posterior disc bulge L5-S1 that does impinge upon and mildly displace the left S1 nerve root. There is a mild anterior

extradural defect on the myelogram with the examinee in the upright position, not confirmed on the supine CT scan.

On December 8, 2009, M.D. performed a peer review on the claimant.

On March 10, 2010, D.O. evaluated the claimant. Diagnosis: Post lumbar laminectomy pain syndrome with recurrent right greater than left lumbar radiculopathy. Generalized deconditioning in a chronic pain state. Reactive depression in a smoker with chronic pain.

On March 31, 2010, April 21, 2010, May 24, 2010, June 29, 2010, and July 19, 2010, D.O. performed follow-up exams on the claimant.

On May 4, 2010, M.D. performed a utilization review on the claimant and denied the request for Lumbar Caudal Epidural Blockade.

On July 12, 2010, M.D. performed a utilization review on the claimant and denied the request for Lumbar Caudal Epidural Blockade.

**PATIENT CLINICAL HISTORY:**

The claimant was injured while working. The claimant has undergone a fusion in 2003 followed by removal of hardware in 2005.

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

Based on ODG Low Back Chapter Criteria for ESI 1.) Radiculopathy must be documented by physical examination **and** corroborated by imaging study and/or electrodiagnostic testing. There are no recent imaging studies or electrodiagnostic studies. The most recent MRI and CT myelogram reports date to 2002. Furthermore, electrodiagnostic studies in October 2002 did not reveal any nerve impingement; therefore, the previous decisions are upheld.

**Per ODG Guidelines:**

Epidural steroid injections (ESIs)

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 by physical examination and 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) for guidance.
- 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)
- 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.
- 9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.

**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)