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Notice of Independent Review Decision

DATE OF REVIEW: November 21, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar caudal epidural steroid injection with MAC including 62311, 77003-26 and 01992 and one office visit 9 – 10 days following ESI including 99213.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The physician reviewer is duly licensed to practice medicine in the state of Texas. The reviewer is fellowship trained in pain management and board certified in anesthesiology with certificate of added qualifications in pain medicine. The physician reviewer has over 23 years of active and current practice in pain management.

REVIEW OUTCOME

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

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Diagnostic (12/05/02)
- Office visits (01/10/11 – 09/16/11)
- Operative reports (02/08/11 – 03/16/11)
- Reviews (02/15/11)
- Utilization reviews (09/23/11 – 10/03/11)

TDI:
- Utilization reviews (09/23/11 – 10/03/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who fell and sustained injuries to her lower back, bilateral knee and right shoulder on xx/xx/xx.

2002: The records start with lumbar myelogram dated December 5, 2002, that revealed mild anterior thecal sac compression at L2-L3 and L3-L4 and moderate at L4-L5; moderate disc space narrowing at L4-L5 and L5-S1 and tapering of the thecal sac in an hourglass configuration at L4-L5 and L5-S1.

2003 – 2010: No records are available.

2011: On January 11, 2011, M.D., evaluated the patient for history of low back pain. Dr. noted the following treatment history: *The patient developed low back pain, right knee and right shoulder pain and left knee pain after the injury. She subsequently underwent surgery to her low back x3, surgery for her knee and surgery for her shoulder, the patient was getting pain management off and on with caudal epidural injections and epidural injections.* The patient was utilizing hydrocodone, Mobic, Cymbalta and tramadol. She reported that most of the time her lower back pain started in the lower back going down to the left foot and sometimes all the way into her toes with numbness in her toes. Surgical history was positive for back surgery, lumbar spine surgery, lumbar fusion surgery, angioplasty and appendectomy, knee scope surgery and shoulder surgery. Examination of the neck and shoulder revealed some tenderness in the neck and shoulder area with pain on the right sided. Examination of the low back revealed tenderness on extension of lateral rotation, positive straight leg raise on both sides eliciting back pain going down her legs and decreased sensation on the left L5-S1 area. Dr. assessed low back pain, failed back syndrome, sacroilitis, shoulder pain and knee pain. He prescribed hydrocodone and Amrix. On February 2, 2011, Dr. performed caudal epidural steroid injection at L4-L5 and L5-S1 and left sacroiliac (SI) joint injection with 50-60% pain relief. Dr. recommended second set of injections.

On February 15, 2011, M.D., performed a peer review and noted the following treatment history: *The patient was status post two surgical procedures on the left knee* and h*ydrocortisone injections. The patient underwent surgical repair of a torn rotator cuff and resection arthroplasty of the acromioclavicular joint. The patient underwent* a *discectomy and fusion from L4 to SI. The preoperative MRI and CT myelogram noted multilevel aging degenerative change, with specific disc space narrowing at L3-L4, L4-L5 and L5-S1. However, on the CT myelogram study of December 2002, there was no spinal stenosis noted and no significant herniation of discs and no instability was noted in terms of subluxation of vertebral bodies one on the other. In 2006, the patient underwent second low back surgery in the form of solid fusion at L4 to SI and decompression L3 and L4 fusion and fixation. A repeat procedure postoperatively required a repair of the meningocele in association with a dural fluid leak. The third low back surgery was performed in 2008 for excision of hardware at the L3-L4 level. The MRI dated February 26, 2010, with and without contrast, noted good vertebral body alignment, no instability findings such as subluxation, evidence of previous hardware removal at L3-L4, diffuse bulge at L1-L2, and a moderate disc bulge at L2-L3 associated with narrowing of the spinal canal to 8 mm in anterior posterior diameter creating moderate canal stenosis. There was moderate left and right-sided neural foraminal stenosis at the L2-L3 level and evidence of previous bilateral laminectomy at L3-L4 without disc bulging and no canal stenosis or*

neural foraminal stenosis at that level. At L4-L5 there was an evidence of a large cystic fluid collection in intradural space causing marked displacement of nerve roots. This cystic collection was noted to have increased in size and bilateral neural foraminal stenosis was noted at L4-L5 with evidence of prior surgery at that level. At L5-SI there was central cystic fluid collection displacing nerve roots laterally both to the right and to the left and evidence of prior laminectomy surgery. The cysts were consistent with intradural arachnoid cysts as a prior surgical complication. The patient was then evaluated by Dr. recommended further surgery with decompression of stenosis at L2-L3 and marsupialization of the arachnoid cysts. Dr. rendered the following opinions: (1) the patient was not a candidate for further surgery for her shoulder and knee. However, occasional cortisone injections to the shoulder were reasonable. (2) In regards the lower back epidural steroid injection (ESI) and facet joint injections were not recommended as per the ODG. (3) Surgery for meningeal cysts would not be reasonable unless there were findings of nerve compression and/or stenosis findings of the lower extremities in association with these cysts. (4) CT myelogram of the lumbar spine would be appropriate if there were progressive neurologic deficits occurring. (5) The treatment was related to the injury or accident. (6) The patient had pre-existing history of chondromalacic degenerative arthritis of the left knee, acromioclavicular joint arthritis and rotator cuff tendinosis of the right shoulder and severe multilevel degenerative disc disease of the lumbar spine which would impact the ability to recover from the injury in question. (7) Ketoprofen could be discontinued without weaning, either tramadol or hydrocodone would be appropriate for the patient's chronic low back pain and Amrix was not recommended by ODG treatment guidelines.

On March 16, 2011, Dr. performed second caudal ESI and left SI joint injection with 95% pain relief for almost two months. In September, the patient complained of recurrence of pain going down the legs and muscle spasm and pins and needles kind of pain starting in back and left buttock and going down the left leg. The patient also reported some numbness and weakness in that leg. Dr. recommended caudal ESI followed by left selective nerve block at L4-L5.

Per utilization review dated September 23, 2011, the request for caudal epidural steroid injection including 62311, 77003-26 and 01992 and one office visit 9 – 10 days following ESI including 99213 was denied with the following rationale *"The epidural steroid injection (ESI) is not indicated. There is no physical exam to document clinical radiculopathy. While the MD did this before, one had great relief and one did not. The caudals were done in conjunction with left sacroiliac injections so it is not possible to determine which helped or how much. Since the injection is not medically necessary, the #01992 MAC is not medically necessary. Also, there is no indication that the patient is medically or psychologically compromised to require this level of sedation. Dr. is an anesthesiologist and should be able to sedate this patient himself. The follow-up office visit is not medically necessary since the injection is not medically necessary. The request for a lumbar caudal ESI with MAC including CPTs #62311, #77003-26, and #01992 is not medically necessary or appropriate."*

Per reconsideration review dated October 3, 2011, the appeal for caudal epidural steroid injection including 62311, 77003-26 and 01992 and one office visit 9 – 10 days following ESI including 99213, was denied with the following rationale *"Based on the clinical information provided, medical necessity for one office visit*

7-10 days following epidural steroid injection (ESI) including is not established. The patient is noted to have sustained an injury in xxxx. She has a history of multiple back surgeries. Most recent imaging study of the lumbar spine is from xxxx, and there is no evidence of neurocompressive pathology. The patient is noted to have subjective complaints of back and leg pain, however, there is no detailed physical examination with assessment of motor, sensory and reflex function. Given the current clinical data, the request for caudal epidural steroid injection and follow up office visit 7-10 days later is not recommended as medically necessary."

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

ACCORDING TO ODG TREATMENT GUIDELINES, EPIDURAL STEROID INJECTIONS ARE INDICATED TO TREAT DISC HERNIATIONS AND/OR NEURAL COMPRESSION THAT CAUSES RADICULAR PAIN IN THE APPROPRIATE DISTRIBUTION OF THE NERVE ROOT INVOLVED WITH EITHER PHYSICAL EXAMINATION OR ELECTRODIAGNOSTIC STUDY EVIDENCE OF RADICULOPATHY. NO MRI DOCUMENTATION OR EVIDENCE WAS PROVIDED INDICATING THAT THERE IS FOCAL DISC HERNATION OR NEURAL COMPRESSION AFFECTING THE CLAIMANT'S LEFT LUMBAR NERVE ROOTS THAT WOULD SUBSTANTIATE AND CORROBORATE THE CLAIMANT'S COMPLAINTS OF LUMBAR AND LEFT LEG PAIN. ADDITIONALLY, THERE IS NO DOCUMENTED PHYSICAL EXAMINATION EVIDENCE PROVIDED BY DR. OF RADICULOPATHY. THERE IS, SIMILARLY, NO DOCUMENTATION PROVIDED OF ANY ELECTRODIAGNOSTIC STUDY EVIDENCE OF RADICLOPATHY. IN FACT, THERE HAS BEEN NO DOCUMENTED EXAMINATION FINDINGS BY DR. SISODIYA SINCE CHECKED THE EXAMINATION DOCUMENT DONE ON JANUARY 10, 2011. THIS LACK OF ANY DOCUMENTATION OF PHYSICAL EXAM FINDINGS EXISTS FOR ALL FOLLOW UP VISITS BETWEEN FEBRUARY AND SEPTEMBER 2011. THEREFORE, ACCORDING TO ODG TREATMENT GUIDELINES, THIS CLAIMANT DOES NOT MEET THE CRITERIA FOR EPIDURAL STEROID INJECTIONS. ADDITIONALLY, THE CLAIMANT'S RESULTS FROM PREVIOUS IDENTICAL EPIDURAL STEROID INJECTION PROCEDURES WERE NOT CONSISTENT; THE FIRST ONLY GAVE HER A COUPLE OF WEEKS OF RELIEF WHILE THE SECOND ALLEGEDLY PROVIDED TWO AND ONE HALF MONTHS OF RELIEF. IN THE ABSENCE OF DOCUMENTED IMAGING STUDY EVIDENCE OF FOCAL DISC HERNIATION OR NERVE ROOT COMPRESSION AS WELL AS ABSENCE OF PHYSICAL EXAMINATION OR ELECTRODIAGNOSTIC EVIDENCE OF RADICULOPATHY, DOING YET ANOTHER EPIDURAL STEROID INJECTION CANNOT BE JUSTIFIED IN LIGHT OF BOTH THE LACK OF MEETING ODG CRITERIA AND THE CLEARLY INCONSISTENT RESULTS OF THE PREVIOUS IDENTICAL PROCEDURES. IN ADDITION, SINCE THERE IS NO MEDICAL REASON OR NECESSITY FOR LUMBAR CAUDAL STEROID INJECTION THERE IS, SIMILARLY, NO MEDICAL REASON OR NECESSITY FOR AN OFFICE VISIT 9 OR 10 DAYS FOLLOWING THE EPIDURAL STERIOD INJECTION. FINALLY, AS WAS POINTED OUT IN THE PEER REVIEW PERFORMED BY DR. KERN ON 2/15/11, THE OPINION WAS THAT THERE WAS NO MEDICAL REASON OR NECESSITY FOR THE CONTINUATION OF "FURTHER TREATMENT OF THE

PATIENT'S LOWER BACK" ACCORDING TO ODG TREATMENT GUIDELINES WHICH I HAVE ALREADY CITED. THEREFORE, THE RECOMMENDATIONS OF THE TWO PREVIOUS PHYSICIAN ADVISORS FOR NON-AUTHORIZATION OF THE REQUESTED PROCEDURES ARE UPHELD. THERE IS NO MEDICAL REASON OR NECESSITY FOR THE REQUESTED PROCEDURE OR FOLLOW UP 9-10 DAYS LATER ACCORDING TO ODG GUIDELINES AS RELATED TO THE CLAIMANT'S WORK INJURY ON XX/XX/XX.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**