

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** October 12, 2011

**IRO CASE #:**

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

Left caudal epidural steroid injection (ESI) times one as related to the lumbar spine

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

Board Certified PM&R and subspecialty certification in Pain Medicine

**REVIEW OUTCOME**

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

X Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Utilization reviews (09/16/11 , 09/21/11)

**Chiropractic**

- Office visits and therapy (04/29/03 – 09/19/11)
- Diagnostics (08/26/03)
- Office visits (04/14/04 - 05/25/11)
- Procedures (04/12/11)
- Pre-authorization requests (08/29/11, 09/19/11)
- Office visits (7/22/98 – 08/26/11)
- Reviews (08/14/00, 10/20/09)
- Procedures (09/28/07 – 04/12/11)
- Utilization reviews (09/16/11 , 09/21/11)

**D.O.**

- Diagnostics (08/26/03 – 11/16/03)
- Office visits (04/15/04 – 08/18/11)

- Procedures (12/21/10 – 04/12/11)
- Utilization reviews (09/16/11 , 09/21/11)

ODG has been utilized for the denials.

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

The patient is a female who injured her lower back on xx/xx/xx, while lifting a box.

**1998 – 2005:** Following the injury, the patient was evaluated by D.O., for low back complaints. X-rays demonstrated narrow disc space at L5-S1. Dr. assessed acute lumbosacral strain and probable lumbar disc injury and treated her with medications, cold packs and transcutaneous electrical nerve stimulation (TENS) unit.

Magnetic resonance imaging (MRI) of the lumbar spine showed a large central herniated nucleus pulposus (HNP) at L4-L5 while a discogram showed a posterior central bulge/herniation at L5-S1. The patient eventually underwent a two-level fusion in 1999 at L4-L5 and L5-S1.

D.O., placed the patient at maximum medical improvement (MMI) on June 20, 2000, with 32% whole person impairment (WPI) rating. Designated doctor D.O., assessed MMI with 16% WPI rating.

From April 2003 through January 2005, the patient underwent extensive chiropractic care under D.C. Modalities were applied to the cervical, thoracic and lumbar areas including joint mobilization, spinal adjustments, manipulations and therapeutic exercises. The diagnoses were low back pain and thoracalgia.

MRI of the lumbar spine obtained in August 2003 showed prior interbody fusions at L4-L5 and L5-S1. A triple phase bone scan obtained in November 2003 showed localized increased activities in the 11<sup>th</sup> and 12<sup>th</sup> ribs, and mild osteoarthritic changes of the knees and shoulders.

In April 2004, D.O., noted the patient had undergone at least three surgical interventions to the lower back but continued with moderate-to-severe pain to the legs and feet. She had become progressively despondent and depressed with pain-related stress and had enrolled herself in a chronic pain management program.

**2006 – 2010:** Dr. continued treating the patient with chiropractic therapy to the lumbar area.

In September 2007, the patient underwent implantation of the spinal cord stimulator (SCS) for the diagnoses of complex regional pain syndrome (CRPS) and postlaminectomy pain syndrome.

From March 2008 through October 2008, Dr. treated her with caudal epidural steroid injections (ESIs) x4, pain medications and SCS. From March 2009 through October 2009, Dr. performed left-sided lumbar sympathetic blocks medications of Norco, Lyrica, and Paxil for anxiety.

In a required medical evaluation (RME) M.D., opined as follows: She had chronic pain syndrome and post-fusion syndrome of the lumbar spine supported by objective evidence, mainly the surgical procedures and scarring. The prognosis was actually guarded, in that she had chronic pain. The length and frequency of treatment was outside the ODG, but fell into the section of exception because of the chronic pain syndrome. She was on Lyrica, which she was now finding beneficial. Continued use of it or off label may still be supported over the next six to 12 months, provided continued improvement and benefit was maintained. The hydrocodone was being prescribed outside of the ODG. She was up to six a day and consideration of tailoring this down to three or four a day in the presence of a working SCS would be appropriate. She did not require any specific weaning to cut back somewhat on the quantity. The frequency of office visits may also be adjusted. She was also receiving epidurals and this did not fit within the ODG, although it gave her at least six to eight months pain relief. If that was the case, then continued epidurals to once or twice a year would be appropriate and if accompanied with a decrease in the amount of narcotics at the same time. Her condition was stable.

From March 2010 through December 2010, Dr. again performed left-sided lumbar sympathetic blocks x5. In April 2010, he replaced the Medtronic SCS.

**2011:** In March and April, Dr. repeated the left-sided lumbar sympathetic blocks. She was continued on a combination of Lyrica, Klonopin and Norco. With the injections she had approximately 70 to 80% benefit. However, she still had shooting pains down her leg and felt that the caudal blocks were more beneficial than the sympathetic blocks. Dr. requested approval of the caudal ESI under fluoroscopy and IV sedation.

On August 18, 2011, Dr. noted the patient had persistent back, buttock and leg pain. SLR test was positive on the left with swelling and hyperesthesia across the dorsum of her foot extending into her mid thigh area. She walked with an antalgic limp and gait and had a notable decreased lumbosacral flexion. Dr. recommended caudal epidural blockade as the patient stated it was the best relief she had gotten since her injury. In the meantime he recommended continuing narcotic, neuropathic and antidepressant medication.

Per utilization review dated September 16, 2011, the request for outpatient left caudal ESI was non-authorized. Rationale: *"The last office visit on August 18, 2011, noted continued complaints of increasing low back, buttocks, and leg pain examination noted positive straight leg raise (SLR) on the left with swelling and hyperesthesia across the dorsum of the foot extending to the thigh areas. She has had several caudal ESIs with the last apparently on October 4, 2008. Her last several injections have been sympathetic blocks. As there is no indication as to the result of the last ESI, there is not sufficient documentation or rationale for an outpatient left caudal ESI x1 as related to lumbar. Thus the request is not medically reasonable and necessary."*

On September 20, 2011, the appeal for outpatient left caudal ESI x1 was non-authorized with the following rationale: *"This individual sustained a back injury on July 3, 1998. Multiple surgeries have been performed including an L4-S1 fusion. There is swelling in the leg; multiple procedures have been performed including lumbar sympathetic blocks, root blocks, caudal ESIs and an SCS. A*

*chronic pain management program has been completed. A caudal ESI was performed on October 14, 2008. Lumbar sympathetic blocks were performed a few months later. ODG stipulate that a radiculopathy should be present that correlates with imaging studies. There is swelling, but no evidence of radiculopathy. There is no documentation of degree and duration of relief from the previous injections. ODG are not met for the requested procedure.”*

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

The patient was denied therapeutic lumbar epidural steroid injections for the reasons as indicated above, 9/16/2011 and 9/20/2011.

I disagree with the conclusions and would recommend proceeding with the caudal epidural steroid injection. First of all, there is documented evidence of a left lower extremity radiculopathy per physical examination by Dr. that meets the ODG criteria, i.e., positive straight leg raise and MRI findings that correlate. Secondly, on 10/20/2009, Dr. MD evaluated the patient during a required medical examination and documented that the patient received 6-8 months of pain relief from her last ESI. This provides the criteria for duration of relief. Dr. has documented that the patient had received greater than 50% relief after the ESI's. This provides the degree of relief, which falls within the 50-70% relief of pain according to the ODG. Furthermore, it is documented by Dr. that the patient decreased her use of Norco from 6-8 per day to 2-4 per day after the ESI and increased her function.

According to the ODG, indications for repeat blocks in the therapeutic phase 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.

In conclusion, the ODG criteria for the requested caudal ESI have been met and the ESI should be approved. Repeat injections, up to 4 blocks per region per year, should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

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

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