

AccuReview

An Independent Review Organization
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Notice of Independent Review Decision

[Date notice sent to all parties]: June 22, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

#3 Caudal ESI

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

This physician is Board Certified Physical Medicine and Rehabilitation with over 16 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured in a work-related accident on xx/xx/xx injuring her low back. She had an altercation with an autistic child and fell

backwards indicating multiple body parts including her cervical, thoracic and lumbar spine, right wrist, elbow and shoulder.

10-22-10: MRI Report for Lumbar W&W/O Contrast dictated by MD. Impression: Internal fixation devices at L4, L5 and S1. Mild left foraminal narrowing at L2-L3 by circumferential osteophytic overgrowth. Slight left foraminal narrowing also seen at L3-L4. Internal fixation device is in excellent position. There is no impingement from its placement.

01-19-12: Clinic note dictated by MD. Impression: Overall claimant is less symptomatic. Symptoms have not been completely eliminated. Most problematic at this time is pain referring into her right buttock and into the thigh and leg on the right. Plan: A caudal epidural steroid injection is being scheduled. Claimant will continue current home exercise program. Two prescriptions given: Hydrocodone and Flexeril.

02-03-12: Caudal Epidural Steroid under Fluoroscopy dictated by, DO. Preoperative Diagnosis: Lumbar Radiculopathy. Findings: After AP and Lateral projections there is a multi-level degenerative disk change, fusion noted. Comment: Last caudal 90% relief for greater than 6 months. 1st Caudal in this series recommend 2nd in 3 weeks depending on effectiveness.

02-14-12: Subsequent progress note dictated by MD. Dr noted the claimant showed significant improvement in symptoms until "severe spasm in LE, claimant stated everything hurt for about 1 ½ hours pulling, cramping, tugging when claimant called ambulance and taken to NU Memorial. Lab work okay, cramping improved, meds made better. C/O lumbar soreness. Impression: successful caudal ESI. Plan: Repeat caudal ESI, improve body mechanics, core strengthening via HEP, and follow up within 3 weeks.

03-16-12: Caudal Epidural Steroid under Fluoroscopy dictated by DO. Preoperative Diagnosis: Lumbar Radiculopathy. Findings: After AP and Lateral projections there is multi-level degenerative disk changes, fusion noted. Comment: After first caudal in this series 1st 40-50% sustained relief, 2nd caudal in this series recommend third in 3 weeks depending on effectiveness.

03-30-12: Subsequent progress note dictated by MD. Claimant noted pain prior to injection 4/10, S/P 2/10. Claimant stated that RLE is back to baseline. Lumbar back pain is still well localized near sacrum with complaints of cramping in right foot, prolonged sitting increases buttock pain. Claimant reports another 30% relief S/P ESI #2 with 70% sustained relief. Claimant stated "still feels like a fireball in the sacrum/buttock area and complained of cramping/drawing up of toes/foot on right. Impression: less symptomatic S/P ESI #2. Plan: Schedule lumbar ESI #3, adhere to proper body mechanics, continue HEP for core strengthening, follow-up after procedure.

04-04-12: UR performed by MD. Reason for denial: This patient has had 2 ESI. The last one completed 3-16-12. The MRI (lumbar) did not show any nerve root entrapment. The necessity for any ESIs was at best equivocal. The ODG would not support the use of a third ESI at this time.

04-20-12: Clinical note dictated by MD. Impression: Overall treatment helping. Claimant's symptoms have definitely decreased with treatment and with epidural steroid injections. Present pain rated 2/10. Further reduction in symptoms is our goal. Plan: Schedule ESI #3. Proper body mechanics reviewed. Continue HEP for core strengthening.

04-25-12: UR performed by MD. Reason for Denial: Based on evidence-based ODG, the specific request cannot be supported. ODG criteria No. 9 regarding the use of epidural steroid injections clearly states "recommended no more than two epidural steroid injections for the initial phase and rarely more than two for therapeutic treatment." Given the fact that the claimant has had two epidural steroid injections in a short course of time, the specific request for a third injection cannot be supported, especially in light of no clinical understanding of neurocompression lesion on imaging.

05-14-12: Subsequent progress note dictated by MD. Claimant complained of increased lumbar back pain midline L5-S1 level referred to both buttocks with increased pain referred into RLE. Dr. noted that claimant benefitted significantly via two ESI and physical therapy. Impression: Claimant would likely benefit from 3rd ESI in part based on favorable response to previous 1st and 2nd ESI. Neck/UE symptoms resolved. Plan: Continue HEP-reviewed today, proper body mechanics-reviewed today, seek approval for 3rd ESI.

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

Denial of third Caudal ESI is upheld/agreed upon. Per ODG Low Back Chapter, submitted clinical notes, there are no objective signs of Radiculopathy. Therefore, the request for #3 Caudal ESI is denied.

Per ODG:

<p>Epidural steroid injections (ESIs), therapeutic</p>	<p>Criteria for the use of Epidural steroid injections: <i>Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.</i></p> <p>(1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.</p> <p>(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).</p> <p>(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.</p> <p>(4) <i>Diagnostic Phase:</i> 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</p>
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	<p>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.</p> <p>(5) No more than two nerve root levels should be injected using transforaminal blocks.</p> <p>(6) No more than one interlaminar level should be injected at one session.</p> <p>(7) <i>Therapeutic phase:</i> 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 supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks 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. (CMS, 2004) (Boswell, 2007)</p> <p>(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.</p> <p>(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.</p> <p>(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.</p> <p>(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.)</p>
<p>Epidural steroid injections, “series of three”</p>	<p>Not recommended. Original recommendations that suggested a “series of three injections” generally did so prior to the advent of fluoroscopic guidance. These previous recommendations were based primarily on case studies and anecdotal evidence (Class IV and V data). (Abram, 1999) (Warr, 1972) (Hickey, 1987) There does not appear to be any evidence to support the current common practice of a series of injections. (Novak, 2008) Contemporary research studies with higher levels of evidence (including two controlled trials) have suggested that on average, two or less ESIs are required in patients with successful outcomes from the use of ESIs to treat disc related lumbar radiculopathy. (Lutz, 1998) (Vad, 2002) (Riew, 2000) While all of these latter studies have utilized repeat injections, there has been no evidence-based research to explain why this practice is required, or the mechanism for possible action. Since the introduction of fluoroscopically guided ESIs, it has been suggested that there is little evidence to repeat an accurately placed epidural injection in the presence of mono-radiculopathy, regardless of whether there is partial or no response. (McLain, 2005) A recent randomized controlled trial of blind ESIs found no evidence to support repeat injections, because at six weeks there was no significant difference found between the ESI group and a placebo controlled group in terms of any measured parameter. (Price, 2005) A repeat injection has been suggested if there is question of accurate dermatomal diagnosis, if pain may be secondary to a different generator, or in the case of multilevel pathology. (McLain, 2005) There is a lack of support for 2nd epidural steroid injection if the 1st is not effective. (Cuckler, 1985) With fluoroscopic guidance, there is little support to do a second epidural if there is no response to the first injection. There is little to no guidance in current literature to suggest the basis for the recommendation of a third ESI, and the routine use of this practice is not recommended.</p>

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)**