CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: October 26, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient lumbar caudal epidural steroid injection (ESI)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified in 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 male who was injured on xx/xx/xx while riding in one of the xx. The ride was very bumpy in the xx and they went over a speed bump and he immediately felt the onset of severe low back pain. He tried to continue activities, but later went to primary care where he was diagnosed with a lumbar strain, treated with medications and taken off work for a week. MRI performed on 01/15/07 and according to Dr., revealed multilevel degenerative disk disease that appeared to be most severe at the three lower levels, and particularly L4-5. There

did appear to be neuroforaminal narrowing on the right at L4-5 and that was confirmed on the axial images where there was broad-based disk protrusion coupled with facet hypertrophy. There also appeared to be a subchondral cyst in the L5 vertebral body just front of the right neural foramen. Facet joints were also hypertrophic at the bilateral L5-S1 level.

On xxxx, the claimant was evaluated by MD who reported he continued to have back pain that he described as burning and stabbing in the center of the low back with aching across the upper pelvic brim. He rated the pain a 5 to 6/10. It was noted he had undergone 2 weeks of physical therapy. Current Medications: Ziac, Zocor, Lexapro, and Fioricet. On physical exam he had a normal gait pattern, some tenderness near the lumbosacral junction, paraspinal muscles had some mild hypertonicity bilaterally and he had some tenderness in the lower bilateral paraspinal tissues. Lumbar ROM was within normal limits, although he did report an increase in pain with extension and right side bending. Lower extremity strength was normal and symmetric. Muscle mass and tone was normal. Sensation was intact in all lumbar dermatomes. Reflexes were symmetrically diminished. Diagnoses: 1. Subacute flare of low back pain following work-related injury specifically being jarred while going over a speed bump. 2. Lumbar facet syndrome. Plan: Bilateral L4-5 and l5-S1 facet injections were recommended, light duty and over the counter medicines.

On February 22, 2007, operative note by MD. Diagnosis: Facet syndrome and low back pain. Procedure: 1. Facet joint injection, L4/5, L5/S1, bilaterally. 2. Fluoroscopic Guidance. 3. IV Conscious Sedation.

On March 9, 2007, the claimant had a follow-up evaluation with MD who reported he had an initial 70% to 80% improvement with the injection and now was at 60% and still had to rely on Darvocet once or twice a day. Plan: Referral to Dr. for chiropractic treatment and request for medial branch block injections for the bilateral L4/5 and L5/S1 facet joints.

On April 2, 2007, the claimant was evaluated by DC who recommended a trial of 6 visits of chiropractic manipulation or office visit along with electric stim, ice, and one unit of therapeutic exercises.

On April 12, 2007, operative note by MD. Diagnosis: Facet syndrome and low back pain syndrome. Procedure: 1. Median branch blocks for facet joints l4/5 and L5/S1, bilaterally. 2. Fluoroscopic Guidance. 3. IV Conscious Sedation.

On April 30, 2007, the claimant had a follow-up evaluation with MD who reported he again had significant relief following the medial branch blocks and his pain decreased to 1/10 and his use of Darvocet down to 0 or 1 a day. Plan: Possibility of doing a rhizotomy.

On June 25, 2007, operative report by MD. Postop diagnosis: Facet arthrosis at the L4-5 and L5-S1 level, status post successful facet joint injections. Procedure: Facet joint denervation rhizotomy with total of 10 lesions performed, and

intraoperative EMG testing of needle positions to ascertain that we are not near a motor nerve.

On August 29, 2007, the claimant was seen in follow-up with Dr. who reported his pain was returning since his rhizotomy a couple of months prior and was rated a 4/10. He had been able to work full duty but was taking Darvocet 3 times a day. Plan: Chiropractic treatment, refill Darvocet and add a Lidoderm patch.

On January 2, 2008, the claimant completed his 11th visit with, DC. He was pre-authorized for 6 visits and then was seen on a p.r.n basis.

On January 2, 2008, the claimant was seen in follow-up with Dr. who report that overall he was much better since he had been doing some intermittent chiropractic treatments. He was still taking Darvocet up to 3 a day, but did not need it every single day. He avoids Darvocet while working and was using a Lidoderm patch with was good success during workdays.

On December 12, 2008, operative note by MD. Diagnosis: Facet syndrome and Low back pain syndrome. Procedure: 1. RF neurotomy for facet joints L4/5 and L5/S1, bilaterally. 2. Fluoroscopic Guidance.

On January 2, 2009, the claimant was seen in follow-up with Dr. who reported he had almost no pain following the rhizotomy and was now about 50% to 60% better and his Darvocet usage was cut in half. He continued to use a Lidoderm patch daily. It was recommended he continue medications and followup in 6 months.

On November 6, 2009, the claimant was seen in follow-up with Dr. who reported his back pain was worsening and that the Darvon and Darvocet were less effective. He continued to use a Lidoderm patch once a day and was continuing full duty as a firefighter, but was having more difficulty at work. Plan: Medication was switched to Hydrocodone and Ultram ER 300 mg.

On January 14, 2010, operative note by MD. Diagnosis: Facet syndrome, Low back pain syndrome and Lumbar spondylosis w/o myelopathy. Procedure: 1. RF neurotomy for facet joints L4/5 and L5/S1, bilaterally. 2. Fluoroscopic Guidance. 3. IV Conscious Sedation.

On February 2, 2010, the claimant was seen in follow-up with Dr. who reported he was virtually 100% better for the first couple of weeks and no the pain was returning, but still fairly well controlled. He continues to take 2 to 3 Hydrocodone a day, Ultram ER once a day, and Lidoderm patch typically one a day. It was also reported he had finished physical therapy that had been prescribed for his previous acute aggravation of his back and was now back down to his usual baseline for this injury. He continued full duty and home exercise program. On examination he had a mildly antalgic gait with some general stiffness. Again general stiffness with range of motion testing in the back which significantly limited with flexion, which aggravated his pain and somewhat with right rotation. Stork maneuver was negative. His medications were refilled.

On July 28, 2010, the claimant was seen in follow-up with Dr. who described his pain as 7-8/10 and burning and aching with occasionally stabbing pain. He denied any radicular symptoms. He reported taking 5 to 6 Hydrocodone a day, and stopped Ultram ER for some reason. On exam he had a normal gait pattern and was nontender to palpation. He had stiffness in all directions, pain mostly with bilateral side bending. Stork maneuver was negative. Plan: Referral to a surgeon for evaluation of possible fusion.

On September 22, 2010, the claimant was evaluated by, MD who on physical exam found manual motor testing was remarkable for a little bit of left-sided weakness with EHL and tibialis anterior both 5-/5 on the left versus 5/5 on the right. Plantar flexors are 5/5 bilaterally as were quadriceps. Reflexes were 1+ at the patella tendons and Achilles tendon. Sitting root test and straight leg raise did not produce pain. Impression: Multilevel diskogenic type pain. Plan: MRI and possibly discography to identify pain generator.

On October 8, 2012, MRI of the Lumbar Spine, Impression: 1. Degenerative disk at all levels in the lumbosacral spine. 2. Spinal stenosis at L3-4 and L4-5. 3. Right paracentral/foraminal disk protrusion contacting the exiting right nerve root at this level. 4. Additional changes impacting the neural elements as described above. 5. Otherwise negative magnetic resonance imaging of the lumbosacral spine without contrast administration.

On October 27, 2010, the claimant was seen in follow-up with Dr. who recommended E-stim, and psychological evaluation for clearance to proceed with discography.

On November 5, 2010, the claimant underwent a behavioral medicine evaluation and was cleared for a discogram.

On December 16, 2010, the claimant was seen in follow-up with Dr. who reported he had been using his electrical stimulator for about a month and had been able to decrease his Hydrocodone usage from 4 to 3 a day. His pain was rated about a 4/10.

On January 31, 2011, the appeal for L3-4, L4-5 and L5-S1 Discogram CT was denied during a UR.

On April 4, 2011, the claimant was seen in follow-up by Dr., who reported the Discogram had been denied. Dr. stated the claimant had maximized nonsurgical measures and recommended stabilizing L3-4 and L4-5 with an anterior interbody construct with minimally invasive posterior stabilization.

On April 8, 2011, the request for L3-4, L4-5 mini 360 fusion with three-day hospitalization was denied during a UR.

On October 28, 2011, the claimant was seen in follow-up by Dr., who reported on

physical exam the claimant had an antalgic gait pattern with some forward bending slightly stiff. He had no hyperreflexia of the upper extremity reflexes or the patellar or Achilles tendon reflexes. There was no ankle clonus noted. He had negative straight leg bilaterally. He had some decrease in sensation of the anterior thighs bilaterally and sensation was grossly intact. He had strength of 5/5 in bilateral upper extremities as well as the quadriceps, hamstrings, gastrocsoleus, anterior tibialis, and extensor hallucis longus bilaterally. He had some tenderness over the lumbar spine in the paraspinal muscles. There was also decreased range of motion of the lumbar spine with pain in forward flexion and extension. Assessment: 1. Disk degeneration in the lumbar spine. 2. Lateral listhesis at the L3-4. 3. Lumbar radiculopathy. 4. Lumbar spondylosis without myelopathy. Plan: Minimally invasive 360 at the L4-5 and L3-4 levels was still recommended.

On August 1, 2012, the claimant was seen in follow-up with Dr. who recommended he continue home exercises, Hydrocodone, Lidoderm and Ultram ER. Epidural Injections for his back were also discussed.

On August 1, 2012, the claimant was seen in follow-up by Dr, for continued back pain. He continued to take Hydrocodone, Ultram Er, Lidoderm patch daily and NSAIDS on a limited basis. On physical exam, he gait was balanced. Paravertebral muscles were non-tender, with no evidence of spasm or trigger point. ROM was painful with flexion and extension. Spinous processes were non-tender and there was no gross neurological abnormalities in the lower extremities. Lumbar ESI's were recommended.

On August 8, 2012, MD performed a UR. Rationale for Denial: The claimant was injured in xx. There was lumbago. The claimant is a male with low back pain at 3 out of 10. The gait is balanced, pelvis level with floor. There is no spasm or trigger point. The request is for an ESI. No MRI or other diagnostic testing is provided. Prior treatment had been physical therapy, a home program, Hydrocodone, Ultram, and Lidoderm. The case does not meet the requisite ODG criteria for radiculopathy for an epidural steroid injection.

On October 1, 2012, , DO performed a UR. Rationale for Denial: The claimant has been treated extensively with physical therapy, medications include opioids, Lidoderm patches, non-steroidal anti-inflammatory drugs (NSAIDS); facet injection, ESI and home exercises. The ongoing medical records note continued requests for lumbar fusion surgery with the ongoing physical examination findings failing to document any focal neurological deficits correlating with imaging study findings. ODG notes radiculopathy as defined by the AMA Guides pages 382-383 to be documented in the medical records. At this time, there are no physical examination findings that correlate with MRI findings documented to support the diagnosis of lumbar radiculopathy in support for the need of an ESI.

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

Denial of caudal ESI is upheld/agreed upon since per ODG Low Back Chapter, submitted documentation does not provide objective evidence of radiculopathy (no radicular pattern, no SLR, no neurologic deficit). And there is no recent MRI or EMG provided. The request for outpatient lumbar caudal epidural steroid injection (ESI) does not meet ODG criteria and is therefore not found to be medically necessary and is denied.

PER ODG:

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, reduction of medication use 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. Radiculopathy must be 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) 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 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)
(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)**