

- Office visits (08/08/12)
- Utilization reviews (09/11/12 – 09/17/12)

Dr. :

- Diagnostics (12/04/07 – 11/22/11)
- Surgery (11/16/10 – 11/22/11)
- Office visits (08/08/12)

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- Office visits (09/14/06 – 09/12/12)
- Diagnostics (09/14/06 – 11/22/11)
- Physical therapy (11/02/06 – 12/17/06)
- Surgery (03/19/07 – 11/22/11)
- Reviews (05/30/07 – 11/05/09)
- Utilization reviews (09/11/12 – 09/17/12)

TDI:

- Utilization reviews (09/11/12 – 09/17/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who on xx/xx/xx, was in a restraining activity on a very and had the onset of low back pain.

2006: The patient was initially seen by M.D., for nagging low back pain radiating to the thighs. Review of systems (ROS) was positive for extremity swelling, decreased range of motion (ROM), joint pain, joint redness, joint stiffness and joint swelling. There was extremity weakness, tingling in the lower extremities and numbness in the left leg, right and left pinky toes. Examination of the spine showed decreased ROM, restricted and painful flexion, tenderness over the right paralumbar region, tenderness over the lumbar vertebra and tenderness over the sacroiliac (SI) region. X-rays of the lumbar spine were unremarkable. Dr. assessed injury of other sites of trunk and prescribed Mobic.

Later the patient was seen at Hospital emergency room (ER) for back pain. The evaluator noted decreased ROM and muscle spasm in the back. He diagnosed acute lumbar myofascial strain and acute low back pain.

On September 28, 2006, Dr. noted that the pain was worse. The patient had tried sleeping in a recliner for positioning and pain control without relief. Dr. obtained magnetic resonance imaging (MRI) of the lumbar spine that showed relatively mild degenerative disc disease (DDD) at L4-L5 and L5-S1 with possible contact of the left L5 nerve root. There was possible small subacute annular fissure at L4-L5 with no compression fracture or vertebral body malalignment. Dr. recommended continuing medications, applying heat and performing stretching exercises.

In October, the patient reported that the pain was about the same. She was not taking any medications. Dr. prescribed Mobic.

From November through December, the patient attended nine sessions of physical therapy (PT) consisting of ultrasound, electrical stimulation, myofascial release and therapeutic exercises.

The patient reported increased pain in the back, neck and shoulders and muscle spasms between the shoulders. Dr. prescribed Skelaxin for degeneration of lumbar or lumbosacral intervertebral disc.

In December, Dr. noted no overall improvement and recommended evaluation by a spine specialist.

2007: From January through March, the patient attended 12 sessions of PT consisting of ultrasound, electrical stimulation, therapeutic exercises, stretching exercise and core strengthening.

D.O., evaluated the patient for low lumbar pain with radiation of pain into the left lower extremity in areas consistent with a left L5 dermatomal distribution. There were paresthesias in the left lower extremity proceeding from the posterior aspect to the lateral aspect of the left calf. The pain was relatively constant and was aggravated with bending, twisting and standing for long periods of time. Examination of the lumbar spine showed the patient rising from a seated position using some assistance from her upper extremities. She had an antalgic gait favoring the right side. She was able to heel and toe walk without substantial difficulty but had exquisite paravertebral tenderness at the left posterior superior iliac spine and left sciatic notch. Lumbar facet loading was equivocal bilaterally and lumbar extension was also equivocal. Straight leg raise (SLR) was positive on the left at approximately 60-65 degrees. Dr. diagnosed lumbar pain with left lower extremity radicular pain accompanied by MRI findings suggesting mild lumbar DDD. In addition, findings suggested lumbar disc bulge with contact of left L5 nerve root and annular tear at the L4-L5 disc suggesting possible association with onset of lumbar pain and radicular pain in the left lower extremity.

On March 19, 2007, Dr. performed a left L5 transforaminal epidural steroid injection (ESI).

Dr. noted that the ESI helped for two days. The patient was not taking Mobic and PT had been stopped.

Dr. noted 80% improvement in the left lower extremity radicular pain that lasted about two days after the injection and on the third day, the pain improvement dropped to only about 10%. The patient continued to report left lower extremity pain in the left L5 dermatomal distribution. Dr. discussed considering a repeat left L5 transforaminal ESI versus left L5-S1 interlaminar approach.

In April and May, Dr. maintained the patient on hydrocodone/ acetaminophen and Mobic.

On May 30, 2007, M.D., performed a designated doctor evaluation (DDE) and opined that the patient was not at maximum medical improvement (MMI). She should have seen a neurosurgeon for ESI. The extent of injury included lumbar disc disease with radiculopathy and strain to the right upper back and the trapezius muscles. The disability was a direct result of the work related injury. The patient could return to light duty.

On June 5, 2007, M.D., performed an ESI at L4-L5.

Dr. noted ongoing severe back pain. The ESI had provided relief for only two days. Dr. recommended follow-up with Dr. as soon as possible.

M.D., evaluated the patient for low back and left leg pain. He noted that the pain was progressive and prevented the patient from working. The pain was across the lower back worse on the left and radiating down to the bottom of the foot. Pain was worse at night and awakened her from her sleep. It was worse with standing and walking and relieved by heat. Dr. reviewed x-rays and MRI and assessed lumbar spondylosis with two level degenerative disc and facet arthrosis. He recommended core strengthening and lumbar stabilization PT and recommended transforaminal selective nerve root block of L4 and L5.

On August 3, 2007, M.D., performed left L4 and L5 selective nerve root injection at L4-L5 and L5-S1 foramen.

Dr. noted 80% improvements from the injections. There was some aching down the back of the left leg. He opined that the patient could benefit from continued PT which had helped in the past.

From August through October, the patient had regular follow-ups with Dr. who recommended continuing PT.

In October, Dr. noted severe pain and inability to sleep at night. He administered Toradol and Kenalog injections and prescribed hydrocodone/ acetaminophen and Mobic. He recommended consultation with a spine specialist.

Dr. noted regression of symptoms to the point where the patient was having severe left leg pain and some urinary incontinence with coughing and sneezing. Dr. refilled Mobic and transferred her care to Dr. for nonsurgical management. He also recommended Medrol Dosepak and Lyrica and ordered a new MRI of the lumbar spine.

On December 4, 2007, MRI of the lumbar spine showed a combination of disc and spur extending into the proximal aspect of each neural foramen at L5-S1 measuring approximately 3 to 4 mm right and 4 to 5 mm left with slightly more disc material identified on the left. There could be slight contact of the left L5 nerve root. There was disc desiccation without disc space height loss at L4-L5 and L5-S1 and some increased signal intensity along the posterior aspect of the

L4-L5 disc space possibly representing some residual hydration or changes of the annular fissure.

On December 4, 2007, Dr. performed left L4-L5 and L5-S1 transforaminal ESI.

On follow-up, the patient reported that she was doing much better and her pain level was down to a minimum. Dr. discussed PT and recommended more of an active-based PT and discussed possible MMI status.

Dr. noted the patient was working full duty and recommended follow-up as needed.

2008: On January 14, 2008, D.O., performed a DDE and opined that the patient was not at MMI as she was still under treatment for her problem and was planning on getting some more injections on as needed basis. There was no mention of surgery. The extent of injury was disc bulge at L5-S1.

Dr. noted right foot and ankle as well as back pain. The patient reported that her foot was better but she had a tender spot on the top. X-rays of the lumbar spine were unremarkable. Dr. recommended follow-up p.r.n. on the foot injury.

Dr. noted that the patient was working full duty but with increased pain in the lower back, left to mild line especially with intermittent pain radiating down the left leg. Examination showed mildly positive left dural tension sign, painful flexion and extension on the left and tenderness on the left. He recommended active PT, left L5-S1 transforaminal ESI #3 and ordered lower extremity electromyography/nerve conduction velocity (EMG/NCV) and a computerized tomography (CT) myelogram of the lumbar spine.

On March 4, 2008, Dr. performed left L5-S1 transforaminal ESI. Dr. prescribed hydrocodone.

In May, Dr. noted that the patient was unable to pick up the hydrocodone that was prescribed and had worsening of her sciatica. He administered injection Toradol and Kenalog.

On June 16, 2008, M.D., performed a DDE and assessed MMI as of June 16, 2008, with 5% whole person impairment (WPI) rating.

In July, Dr. noted increased pain down the left leg. The patient had elevated her leg and that seemed to make it worse. She also had severe pain causing her to vomit. Dr. administered Toradol and Kenalog injection and prescribed hydrocodone/acetaminophen.

In December, the patient reported that she was doing well until the cold weather hit and she had more pain. Dr. administered Toradol and Kenalog injections and hydrocodone/acetaminophen and Skelaxin.

2009: In April, Dr. noted worsening low back pain. Examination showed decreased ROM, painful movement, restricted and painful flexion and extension, pain with left and right side bending and tenderness over the lumbar vertebra. SLR was negative on the left and right. Dr. administered Toradol and Kenalog injections, prescribed hydrocodone/acetaminophen and Mobic and ordered an MRI.

On April 22, 2009, MRI of the lumbar spine showed a mild bulging at L4-L5 with mild DDD, mild retrolisthesis of L5 on S1, osteophytic overgrowth and bulging extending into the neural foramina with closed proximity to the left greater than right L5 dorsal root ganglion and no nerve root displacement.

M.D., evaluated the patient for severe low back pain with radiation down the left lower extremity. Examination showed positive tension signs on the left side reproducing back pain and left posterior thigh pain. Dr. assessed internal disc derangement at L4-L5 and L5-S1 and lumbar radicular syndrome. He opined the patient was a candidate for lumbar spinal reconstruction as she had failed non-operative treatment for over two years' duration.

In a behavioral medicine consultation, the patient was diagnosed with pain disorder associated with both psychological factors and a general medical condition. The evaluator cleared the patient for surgical intervention.

In June, Dr. treated the patient with injection of Kenalog and Toradol, prescribed hydrocodone/acetaminophen, meloxicam and Soma and ordered MRI of the thoracic spine.

In July, x-rays of the thoracic spine showed variability in appearance of the spinous processes in the upper thoracic spine of doubtful significance.

On July 5, 2009, the patient was evaluated at Hospital ER for pain in the low back radiating to the left leg. She was treated with Lortab and tramadol.

On July 16, 2009, Dr. noted that the patient was awaiting a surgical evaluation with a discogram study which was denied. He prescribed Ultram, hydrocodone and Lyrica.

On August 27, 2009, lumbar discogram revealed significant pressure but no pain on injection at L3-L4 with mildly irregular collection without fissuring. At L4-L5, there was severe 10/10 similar right low back pain with right hip numbness and occasional hurting and posterior fissuring with delayed left-sided epidural extravasation. At L5-S1, severe 10/10 concordant left low back pain with additional similar right leg pain and numbness, anterior and posterior fissuring, likely morphologic disc herniation and epidural contrast extravasation with disc narrowing.

Post-discogram CT scan showed posterior fissuring at L4-L5 with findings suggestive of a 3-mm posterior central disc protrusion and contrast noted within the left neural foramen and the epidural space which might originate from that

level or the level below. Some of the increased density within the left neural foramen could also possibly be related to a left foraminal disc protrusion. Diffuse annular fissuring at L5-S1 with a 3-mm broad-based posterior disc protrusion suspected. There was increased density within the left neural foramen. It was not clear if this was related to the extravasated contrast or a left foraminal disc protrusion. MRI could be performed for further evaluation of the L4-L5 and L5-S1 levels as indicated.

In October, Dr. noted that the request for lumbar surgery was denied. He recommended continuing Lyrica and ordered EMG/NCV of the left lower extremity.

The patient underwent EMG/NCV of the left lower extremity on October 29. However, the report is incomplete.

In November, Dr. opined that the patient had failed non-operative treatment and was a candidate for reconstruction at L4-L5 and L5-S1.

M.D., performed a medical evaluation and opined that the patient had appropriate non-surgical treatment for her back and had not reportedly received any real significant relief for the last nine months. He felt that the patient was a candidate for spinal surgery. However, there were no real guarantees that she would improve with the two-level proposed anterior and posterior fusion with a nerve root decompression.

On December 15, 2009, Dr. performed L4-L5 radical discectomy to the level of the posterior longitudinal ligament including both lateral recess and foraminal decompression; L5-S1 radical discectomy to the level of posterior longitudinal ligament including both lateral recess and foraminal decompression; L4-L5 and L5-S1 anterior lumbar interbody fusion (ALIF), L4-L5 and L5-S1 intervertebral device and allograft for spinal fusion.

Postoperatively, the patient continued to experience pain and weakness on the left side. Dr. prescribed Norco and Flexeril, and increased Lyrica from 200 to 400 mg. He recommended PT.

2010: In January, Dr. noted some improvement. The patient complained of worse symptoms on the left side. Examination showed mild weakness graded 4/5 in the left anterior tibialis and left extensor hallucis longus. Dr. diagnosed L4-L5 and L5-S1 fusion and lumbar radicular syndrome. He recommended starting PT and continuing hydrocodone and Lyrica.

From January through April, the patient attended 26 sessions of PT consisting of hot pack/cold pack, therapeutic exercises and therapeutic activities.

In March, Dr. noted that the patient had fallen down the stairs and landed on her back. She was worried because she had spinal fusion. Examination showed

weakness graded as 4/5 on the left anterior tibialis, extensor hallucis longus and 5/5 in the left gastro-soleus. There was exquisite tenderness directly over the left-sided pedicle screws with reproduction of back and leg pain. Dr. felt that the patient would be a candidate for fusion exploration and hardware removal with the goal of reduction of pain on the left side.

On April 14, 2010, Dr. performed left L4-L5 and sacral pedicle screw hardware block. There was 80% pain relief for up to six to eight hours after the injection.

On June 8, 2010, Dr. performed exploration of fusion at L4-L5 and L5-S1, removal of hardware left side only L4-L5 and L5-S1, fusion augmentation L4-L5 and L5-S1 and allograft for spinal fusion and iliac crest aspiration x4. Postoperatively, the patient was maintained on hydrocodone, Ultram ER, Klonopin, Lyrica and Zanaflex. The patient reported that she had a lot more pain than she was expecting after the hardware removal. Dr. discussed switching her from Zanaflex to baclofen and ordered a transcutaneous electrical nerve stimulation (TENS) unit.

From July through October, the patient attended 15 sessions of PT.

In September Dr. discussed trying an alternative neuropathic medication. He recommended tapering off Lyrica and prescribed Topamax.

On October 6, 2010, Dr. performed a left SI joint block. The patient reported that she had significant relief of pain after injection. Dr. recommended a second confirmatory SI block on the left side. He refilled tramadol ER and Klonopin.

On follow-up, Dr. recommended continuing care with Dr.. He opined that the patient would be a candidate for an SCS if SI rhizotomy or injections were not effective in relieving the pain.

On October 27, 2010, M.D., evaluated the patient for chronic left lumbosacral pain. The patient continued to have a lot of pain in spite of treatment. Examination showed tenderness at the left SI notch compared to the right, positive Patrick's on the left compared to the right and positive Stork on the left compared to the right. He assessed chronic low back pain and lumbosacral spondylosis with history of lumbar fusion and subsequent left-sided hardware removal, failure of conservative management and positive response to the SI joint block. He recommended considering a cooled SI joint rhizotomy for the left L5, S1, S2 and S3 lateral branches.

On November 16, 2010, Dr. performed incomplete left L5 radiofrequency rhizotomy. The procedure was abandoned 1.5 minutes into the rhizotomy lesioning procedure. The patient began to cough uncontrollably and then had an episode of emesis. The procedure was abandoned due to the risk of possible aspiration. The patient was rolled into the supine position and was stabilized with suction and bag-valve mask.

In December, Dr. noted left-sided lumbosacral spine pain. He recommended Zantac 150 mg twice a day for one week leading up to the procedure of L5, S1, S2 and S3 rhizotomy.

2011: In March, Dr. performed left L5, S1, S2 and S3 branch rhizotomy. Postoperatively, Dr. noted the patient still had some discomfort. She was utilizing her medications including hydrocodone, tramadol, Klonopin and Topamax. Dr. recommended continuing medications and follow-up with Dr. in a month.

In May, Dr. noted the patient had left-sided buttock pain, numbness, sharp pains, aching across her lower back and pain radiating down her leg into the lateral aspect of her foot. She felt achiness in her foot that was constantly there. Dr. recommended trial of a spinal cord stimulator (SCS).

In May, Dr. evaluated the patient and agreed with Dr. recommendation for SCS.

On May 27, 2011, Ph.D., performed a behavioral medicine evaluation for pain in the left leg with burning and numbness and stabbing sensation in the left hip. The patient also had low back pain. The patient scored 17 on Beck Anxiety Inventory (BAI) indicating mild to moderate anxiety. She scored 13 on CES-D indicating mild depression. Dr. cleared the patient for the stimulator.

In August, Dr. noted that as the patient had a car trouble prior to the stimulator trial it had been cancelled and rescheduled. He prescribed Zanaflex, Topamax and Ambien CR and discontinued Klonopin.

In November, Dr. scheduled the patient for SCS with Dr.. He opined that if the patient was doing better after the trial, then she might be a candidate for weaning off her medications and possibly considering her for referral to Spinal Rehab.

On November 22, 2011, Dr. performed percutaneous trial implantation of an 8-electrode SCS lead to the level of T8.

On November 29, 2011, Dr. noted the patient reported more than 50% pain relief. The patient also reported some ability to stand, walk and sit for longer periods of time with less levels of pain. However, she continued to hurt in spite of the stimulator device.

2012: In January, Dr. noted the patient had more than 50% relief but she backed out of going through the actual implant. The patient felt that she wanted to lose some weight first. Her BMI was 38. She was working with her primary care doctor about possibly going on a diet and possibly even considering a gastric band versus gastric bypass to lose weight and she was hopeful that would help with her back pain and help her get off of her pain medications as well. Dr. noted presently tizanidine was effective for the patient but the Klonopin was not effective for her sleep. He discussed switching her to zolpidem or Ambien. She would not require refills of her hydrocodone, tramadol ER or Topamax. Dr. discontinued Klonopin.

On April 25, 2012, Dr. noted the patient had lost about 40 pounds. She was doing fairly well. She still had a stabbing pain in her left buttock on the left side radiating down the leg. The patient was utilizing Topamax, tramadol ER and hydrocodone. Dr. discussed refill of Topamax. The Ambien did not help her sleep. Dr. prescribed cyclobenzaprine, baclofen, gabapentin, tetracaine and topical pain gel #7 with diclofenac and recommended a urine drug screen.

On August 8, 2012, the patient reported a flare-up of her leg pain that started about three weeks ago, subsequently the back pain started to get worse. She had been utilizing hydrocodone, Topamax, tizanidine and tramadol. She had an antalgic gait on the left. Examination of the lumbar spine showed positive dural tension sign on the left with no motor weakness or paresthesia. Dr. assessed flare-up of left leg pain, prescribed a Medrol Dosepak and continued hydrocodone, tramadol ER, Ambien and Topamax.

On August 22, 2012, Dr. recommended epidural steroid injections (ESI).

Per the utilization review dated September 11, 2012, the request for caudal ESI at L5-S1 was denied based on the following rationale: *“The claimant injured her low back on xx/xx/xx. The last office visit on August 8, 2012, noted flare-up of left leg pain that started about three weeks ago, back pain started to get worse. On examination, the claimant is 5’7”, 205 pounds with antalgic gait on the left, positive dural tension sign on the left with no motor weakness or paresthesia on lower extremity examination and no signs of clubbing or edema. The last ESI by note appears to have been on February 22, 2008. The request is for outpatient lumbar caudal ESI related to L5-S1. As there is no documentation as to the result of the last ESI, there is not sufficient documentation or rationale for outpatient lumbar caudal epidural steroid injection related to L5-S1. Thus the request is not approved.”*

On September 12, 2012, Dr. evaluated the patient for ongoing left lower back pain and left leg pain. The patient reported worsening of her left-sided lower back and radiation to the left lower extremity. She was asking about an injection. She had previously failed a left sacroiliac joint rhizotomy. She had an antalgic gait to the left. Examination of the lumbar spine showed paravertebral muscle tenderness bilaterally, painful ROM and painful restricted flexion to 50% of normal, painful extension at 50% of normal, positive straight leg raise (SLR) on the left at 45 degrees and pain with seated SLR located at the buttocks and thigh. The left light touch was abnormal at L5. Dr. recommended left L5-S1 transforaminal ESI.

Per reconsideration review dated September 17, 2012, the appeal for lumbar caudal ESI at L5-S1 was denied based on the following rationale: *“According to the documentation, the claimant injured her low back on xx/xx/xx. The claimant had back and left leg pain. The claimant has had two lumbar surgeries including a spinal cord stimulator (SCS) implant done at the T8 level. According to the documentation, the claimant had coverage of bilateral limb symptoms. The last ESI documented was on February 22, 2008. The claimant saw Dr. on August 8, 2012. The claimant had a flare-up of left leg pain. The claimant was placed on*

Medrol Dosepak and then discharged. There is a request of a repeat ESI. According to ODG, the utilization of repeat ESI is supported if the claimant receives at least fifty (50) percent (%) relief for six to eight (6-8) weeks. There is lack of documented evidence of outcomes, functionally or objectively, from the previous ESI. Examination showed antalgic gait with positive dural tension sign on the left with no neurological deficits. Therefore, per the ODG the request for caudal ESI is not supported.”

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

In this case, the patient has in fact been treated with ESI in the past. Per the ODG, 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 benefit. The last ESI documented was on February 22, 2008. According to the ODG, indications for repeating ESIs in patients with chronic pain at a level previously injected (>24months) include a symptom-free interval or indication of a new clinical presentation at the level. On December 15, 2009, Dr. performed L4-L5 radical discectomy to the level of the posterior longitudinal ligament including both lateral recess and foraminal decompression; L5-S1 radical discectomy to the level of posterior longitudinal ligament including both lateral recess and foraminal decompression; L4-L5 and L5-S1 anterior lumbar interbody fusion (ALIF), L4-L5 and L5-S1 intervertebral device and allograft for spinal fusion. Post-surgically, the patient underwent a significant course of conservative treatments as outlined above but no ESIs. Radiculopathy has been documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In my opinion, the patient is post surgical intervention and has an indication of a new clinical presentation at the level and thus meets the ODG criteria for therapeutic ESI.

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-eight weeks, with a general recommendation of no more than 4 blocks per year, per the ODG. Thus, no additional ESIs are indicated if the above criteria are not met.

This case was upheld due to the request for a caudal ESI. According to the ODG, a transforaminal approach technique allows for delivery of medication at the target tissue site, and an advantage for transforaminal injections in herniated nucleus pulposus over translaminar or caudal injections has been suggested in the best available studies. Two recent RCTs of caudal injections had different conclusions. This study concluded that caudal injections demonstrated 50% pain relief in 70% of the patients, but required an average of 3-4 procedures per year. (Manchikanti, 2011) This higher quality study concluded that caudal injections are not recommended for chronic lumbar radiculopathy. Thus, a caudal ESI is not recommended.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES