

Health Decisions, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: August 16, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 caudal epidural steroid injection under fluoroscopy and IV sedation between 6/21/2013 and 8/20/2013

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

This physician is Board Certified in Anesthesiology and has experience in Pain Management.

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:

07/27/09: Electrodiagnostic Results

11/02/09: MRI of the Lumbar Spine

04/18/11: MRI of the Lumbar Spine

02/13/12: Initial Behavioral Medicine Consultation

05/07/12: MRI of the Lumbar Spine

10/19/12: Psychological Testing and Assessment Report

12/10/12: History and Physical

12/14/12: Surgical Referral Form

01/08/13: Follow-up Evaluation

01/22/13: Follow-up Evaluation

02/27/13: Initial Pain Evaluation

03/27/13: Follow-up Note

04/18/13: Follow-up Note

03/28/13: Initial Evaluation

05/07/13: Assessment/Evaluation for Chronic Pain Management Program

05/07/13: Physical Performance Evaluation
05/13/13: History and Physical Chronic Pain Management Program
05/23/13: Follow-up Visit
06/13/13: Follow-up Note
07/02/13: UR performed
07/08/13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a work-related injury on xx/xx/xx while performing his customary duties. His back began hurting with burning pain. He ultimately underwent physical therapy and injections and underwent a lumbar micro discectomy at L5/S1 in November of 2011. He underwent extensive postoperative physical therapy and additional injection following the 2011 surgery.

July 27, 2009, Electrodiagnostic Results: The only significant abnormalities are fibrillations in the left L4 paraspinous, left L5 paraspinous, and right L5 paraspinous muscles. These abnormalities suggest a bilateral L5 radiculopathy and an L4 radiculopathy on the left. The possibility of spinal stenosis with multiple nerve root impingement should be considered.

November 2, 2009, MRI of the Lumbar Spine, Impression: 1. 4mm posteriocentral disk protrusion at L5-S1, which mildly impinges upon the thecal sac and both of the S1 nerve root sheaths. The disk protrusion moderately narrows both of the lateral recesses. 2. 2mm posteriocentral disk protrusion at L2-L3. 3. Full-thickness radial tear seen in the posterior fibers of the intervertebral disk at L5-S1.

April 18, 2011, MRI of the Lumbar Spine, Impression: 1. 4mm posterior central disk protrusion at L5-S1, which mildly impinges upon the thecal sac and both of the S1 nerve root sheaths in the lateral recesses. The disk protrusion moderately narrows both of the lateral recesses at this segment as well. 2. Acute, full thickness tear of the posterior fibers of the intervertebral disk at L5-S1.

May 7, 2012, MRI of the Lumbar Spine without and with contrast, Impression: 1. 2mm recurrent posterior disc protrusion at L5-S1, which mildly impinges upon the thecal sac. There is also a moderate to large region of enhancing scar tissue which fills the entirety of the right lateral recess, also surrounding and displacing the right S1 nerve root. The scar tissue measures 9x11x10 mm. 2. 3mm posterior central disc protrusion at L4-L5, which mildly impinges upon the thecal sac. 3. Mild disc desiccation at L5-S1.

December 10, 2012, the claimant presented with chronic low back and bilateral referred hip pain. It was noted a request for authorization of a 360 fusion had been denied and was referred for a 2nd opinion. On physical examination he had an antalgic gait, hesitant forward bending and straight leg raise limitation that referred pain out to both hips at 60 degrees. Knee jerks and ankle jerks were minus one and symmetric trace weakness of his right gastrocnemius. Assessment: Chronic progressive lumbar radicular syndrome in conjunction with bilateral lateral recess stenosis and facet hypertrophy with associated this

desiccation. Plan: To adequately decompress the recurrent herniated disc and the bilateral facet hypertrophy causing his referred bilateral hip pain, opined that he needed bilateral laminectomy and facetectomy. Because of the need for removal of the bilateral facet complex the claimant would also need the addition of pedicle screw fixation and lateral mass fusion.

January 22, 2013, the claimant had a follow-up evaluation for continued back pain that radiated into his legs following surgery with fusion a month prior. Plan: Given additional Hydrocodone and Tramadol.

February 27, 2013, the claimant was evaluated for complaints of severe pain in the low back radiating down into both legs, down the back and right approximately to the knee levels. On physical examination he had a somewhat antalgic gait. There was moderate-to-severe tenderness overlying the lumbar area, well-healed surgical scars, and severe tenderness overlying the quadratus lumborum musculature bilaterally. Assessment: Post-laminectomy syndrome. Plan: Continue to treat with medications.

April 18, 2013, the claimant had a follow-up evaluation who noted that since starting physical therapy, he reported his pain was substantially increased in both of his right hip and the pain radiating down the left leg. It was noted that he may need a caudal epidural steroid injection with lysis of epidural adhesions.

May 23, 2013, the claimant had a follow-up evaluation who noted he was five month postoperative and still having significant residual back and left leg discomfort. It was further noted he was seeing a pain management physician who was arranging for work-hardening. wanted to establish whether he had satisfactory lumbar fusion and adequate flexion and extension x-rays of the lumbar spine as well as a CT lumbar myelogram.

June 13, 2013, the claimant had a follow-up evaluation for refill of his medications. It was noted he had undergone 9 sessions of physical therapy which had not helped him. He continued to complain of severe low back pain radiating down the back of both legs down into the heels. On physical exam he continued to have moderate-to-severe spasm of the quadratus lumborum musculature bilaterally starting at approximately L3 downwards, tenderness overlying midline and lateral in the lumbar spine. PSIS tenderness bilaterally. Positive straight leg raise with positive sciatic stretch bilaterally, left greater than right. There was perhaps some slight decrease in muscle strength, 4+/5 bilaterally in the lower extremities. There appeared to be slight decrease in sensation in the S1 distribution bilaterally. Assessment: Post back surgery syndrome with probable epidural scarring and lumbar radiculopathy. Plan: He likely has some epidural scarring, status post surgery, and some continued inflammation around the nerve supplying lower extremities. recommended a caudal epidural steroid injection to settle down the inflammation post surgery. This would hopefully decrease his pain to the point where he could be more aggressive doing his stretching exercises on a regular basis and hopefully get him to return to work. He would do the caudal ESI with catheter to try to reach up to the surgical area and direct it more towards the

lateral recesses. Because the claimant has a moderate amount of pain and complains that he has severe difficulty lying prone, he would need very heavy sedation to tolerate the procedure, so they would schedule Anesthesia for sedation and airway management.

July 2, 2013, performed a UR. Rationale for Denial: In regard to epidural steroid injection the guidelines criteria for ESI state radiculopathy must be documented, objective findings on examination need to be present and radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. According to the available records the documentation indicate radiculopathy, however there are no recent imaging studies or electrodiagnostic testing that would support radiculopathy. Records reflect the most current MRI was on 5/7/2012, which was prior to the surgery on 12/14/2012. Therefore based on the aforementioned and guideline support, the prospective request for 1 caudal epidural steroid injection under fluoroscopy and IV sedation is recommended non-certified.

July 8, 2013, performed a UR. Rationale for Denial: Regarding this patient, an ESI does not appear medically necessary at this time. Although the provider has included objective findings in his documentation supporting radiculopathy, there remains no recent imaging studies or electrodiagnostic testing following the L5-S1 fusion in December of 2012. In an effort to obtain the additional information necessary to support the medical necessity of the request, at 12:45 pm on 7/8/13 telephone contact was made. He identified his rationale for not having pursued a postoperative MRI, and was concerned that postoperative imaging will identify postoperative changes only. But he expressed an intention to request a postoperative MRI, and if that postoperative imaging is inconclusive, he will consider requesting a diagnostic ESI. The ESI request would be based upon subjective and objective radicular findings that persist despite conservative treatment and the inconclusive imaging. Therefore, the provider's request for a 1 caudal epidural steroid injection under fluoroscopy and IV sedation is recommended non-certified.

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

The previous adverse determinations are upheld. In order to substantiate this request for caudal epidural steroid injection there must be objective findings as well imaging studies and/or electrodiagnostic testing. Though there are objective findings of radiculopathy, there are no recent imaging studies or electrodiagnostic testing performed after the L5-S1 fusion in December 2012 that demonstrate radiculopathy. The most recent MRI was completed prior to surgery on 12/14/2012. Therefore, based on the guidelines, the request for 1 caudal epidural steroid injection under fluoroscopy and IV sedation between 6/21/2013 and 8/20/2013 is non-certified.

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)**