**Matutech, Inc**
**881 Rock Street**
**New Braunfels, TX 78130**
**Phone: 800-929-9078**
**Fax: 800-570-9544**

---

Notice of Independent Review Decision

**September 10, 2013**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
Caudal epidural steroid injection under fluoroscopy with IV sedation at L5-S1

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

**REVIEW OUTCOME:**

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

☒ Overturned (Disagree)

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

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Reviews (07/09/13, 08/12/13)

- Office visits (04/18/07- 07/25/13)
- Procedure (08/20/08 - 12/01/10)
- Reviews (07/09/13, 08/12/13)

- Office visits (07/14/08 – 07/25/13)
- Procedure (12/01/10)
- Reviews (07/09/13, 08/12/13)

**ODG criteria have been utilized for the denials**

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The patient is male who on xx/xx/xx, felt a pull in his back.
On April 18, 2007, performed a medical evaluation and noted the following history:
*The patient underwent magnetic resonance imaging (MRI) of the lumbar spine on*

*January 6, 2006. In a report indicated a right paramedian L4-L5 disc herniation extending cephalad. noted that there was ventral thecal sac compression and crowding of the cauda equina. In addition, at the same level there was severe right and mild left neural foraminal stenosis at L4-L5. At L5-S1 there was a broad-based disc protrusion superimposed upon bulging annulus/osteophyte complex contacting the S1 nerve roots bilaterally. There was also associated moderate bilateral neural foraminal stenosis with contact of the L5 nerve roots. also noticed the previous surgery of right L4 hemilaminectomy. He reported limited ventral epidural granulation tissue enhancement.*

*The patient underwent an electromyography (EMG)/nerve conduction velocity (NCV) study performed on June 19, 2006. reported bilateral L4 and L5 radiculopathies and a right S1 radiculopathy. He further stated that the possibility of spinal stenosis and multiple nerve root impingement should be considered.*

*On December 4, 2006, noted that the patient had been lifting when he had the onset of low back pain. The patient had undergone hemilaminectomy on the right at L4 previously. the patient underwent a physical performance test performed. She noted that the patient had made fair progress with previous rehabilitation programs and there were significant deficits in trunk range of motion (ROM), right lower extremity strength and functional limitations. As a result, she recommended resumption of a pain management program to include physical therapy and conditioning.*

*On December 21, 2006, the patient underwent a psychological screening. felt that the patient was an excellent candidate for multidisc chronic pain management program (CPMP). On March 23, 2007, noted that the patient had completed four weeks of CPMP, however, the patient remained quite symptomatic. The patient stated that he had previously been asymptomatic following his surgery but that upon lifting, his symptomatology had returned and was now primarily right-sided leg pain. For that reason referred the patient for evaluation.*

opined that the patient had reached maximum medical improvement (MMI) with 10% whole person impairment (WPI) rating.

On June 14, 2008, evaluated the patient for chronic, persistent axial back, left buttock and left leg pain. The patient had failed conservative, rehabilitative and surgical intervention. noted that the patient had recovered from prior back surgery. The patient felt that he had exacerbated his prior condition. Since that time, he had had persistent left foot and left leg pain requiring walking with an antalgic limp and cane support device. He admitted to numbness, weakness and pain currently graded 7/10 aggravated to 10/10 with most routine daily activities. Examination revealed moderate lumbar interspinous tenderness with a positive straight leg raising (SLR) sign on the left at 60 degrees. assessed post lumbar laminectomy pain syndrome with recurrent left lumbar radiculopathy, myofascial pain syndrome with generalized deconditioning, moderate reactive depression and anxiety in a smoker with chronic pain. He recommended the use of Wellbutrin, Klonopin, Norco and Neurontin; eliminating the cane support device to regain activities of daily living (ADLs) and recommended injection therapy in the form of caudal epidural blockade with lysis of adhesions.

On July 28, 2008, the patient reported at least 20% to 30% improvement with institution of medication management. He had better sleep and affect. He had moderate left sciatic notch tenderness with a positive straight leg raising (SLR) sign with pain below the level of the knee. discussed caudal epidural blockade with lysis of adhesions technique.

On August 20, 2008, performed introduction of caudal epidural catheter under fluoroscopy, lysis of epidural adhesions, injection of contrast with performance of epidurogram and injection of corticosteroid and local anesthetic solution.

On September 4, 2008, the patient reported at least 50% improvement of his right leg pain complaint, his axial back pain, following a single caudal epidural block. He walked with greater ease and used his cane less. He had cut his Norco down to only two tablets per day. He took Neurontin for neuropathic complaints. He still had a positive SLR on the right. recommended a second through third caudal block.

**2009:** No records are available.

**2010:** On October 14, 2010, the patient reported more than 70% improvement of his back, right buttock and right leg pain complaints following a single caudal epidural black some three to four weeks ago. He was more functional and more active. recommended going ahead and scheduling the patient for a second through third caudal block as long as each block offered him further and further improvement for his work-related injuries.

On December 1, 2010, performed introduction of caudal epidural catheter under fluoroscopy, caudal epidurogram, lysis of adhesions and injection of corticosteroid and local anesthetic solution.

On December 14, 2010, the patient reported more than 90% improvement of his right back, buttock and leg pain. His leg pain had nearly completely resolved following the ESI. He was able to cut down on his weak narcotic analgesia and walked with greater ease. recommended a second procedure to be done in one to two weeks time.

**2011:** On October 4, 2011, noted that the patient walked with an antalgic limp. He was using a cane support device. His leg pain had started to come back. He felt that his back pain was back up to 7-8/10 despite Norco four times per day. refilled Wellbutrin, Neurontin and Klonopin and recommended taking some nonsteroidal anti-inflammatory drugs (NSAIDs) over the next seven to 10 days. If his pain persisted, a repeat caudal epidural blockade versus a trial of spinal cord stimulation (SCS) would be suggested.

**2012:** From January 5, 2012, through October 4, 2012, the patient had follow-ups every three months for care regarding his back pain complaints associated with post-lumbar laminectomy pain syndrome and recurrent radiculopathy. He was utilizing Norco, Neurontin, Wellbutrin and Klonopin. His urinalysis was consistent

with the agents he was receiving. encouraged the patient for continued rehabilitative efforts.

**2013:** On January 3, 2013, evaluated the patient for post lumbar laminectomy pain syndrome with myofascial pain syndrome. The patient was utilizing Wellbutrin, Neurontin, Klonopin and a weak narcotic and analgesic. He had a positive SLR on the left. He had some facet tenderness. recommended continuing oral medications.

On April 1, 2013, noted that the patient was in the process of weaning from clonazepam. He recommended a natural hypnotic agent such as Somnacin. The patient was receiving Norco and Wellbutrin with good result. His affect was good. He was getting fair analgesia with a combination of Neurontin and these medications. His medicines had come down dramatically to three to four tablets per day. He had used caudal epidural blockade for acute flare-ups with good results. His pain was 3-4/10. He had mild positive SLR sign and mild lumbar interspinous tenderness. recommended follow-up in three months.

On June 7, 2013, noted that unfortunately the patient's medicine was not being filled as prescribed, Somnacin, a natural hypnotic sleep aid was not filled under Workers Compensation. It was noted that the patient was not sleeping with his post lumbar laminectomy pain syndrome. He was taking his Wellbutrin and Norco as prescribed as his Neurontin. He was walking with antalgic limp and gait. His insomnia associated with this pain continued to be problematic. He had a positive SLR on the right. gave Ambien to the patient.

On June 27, 2013, the patient reported feeling that his back, buttock and leg pain had returned to approximately 70% of what it was previous to the injection therapy. He was now walking with an antalgic limp and gait. He had a positive SLR on the right with moderate right sciatic notch tenderness; decreased pinprick sensation as seen before in the L5-S1 distribution with a positive contralateral straight leg raising sign on the left. He had failed conservative, rehabilitative and medical treatment options. For this acute exacerbation, the patient wanted a caudal epidural blockade, which had helped to reduce his pain more than 80 to 90% in the past. He was maintained on Norco, Wellbutrin, Ambien and Neurontin. recommended going ahead with caudal epidural blockade.

Per utilization review dated July 9, 2013, the request for lumbar caudal ESI under fluoroscopy and intravenous (IV) sedation at L5-S1 was denied with the following rationale: "*The ODG detail in the criteria for epidural steroid injections that, "Radiculopathy must be documented with objective findings on examination and corroboration with imaging and/or electrodiagnostic testing. Additionally, notes indicate the patient should be initially unresponsive to conservative treatments, to include exercises, physical methods, NSAIDs, and muscle relaxants." However, the documentation submitted for review does not support the request. While notes indicated that recent examination of the patient noted a decreased pinprick sensation in an L5-S1 distribution and a positive contralateral SLR sign on the left and while notes indicated that the patient had failed conservative, rehabilitative*

*and medical treatment options, there is a lack of documentation submitted for review to clearly delineate what conservative measures that have failed for the patient prior to the most recent request for ESI. Additionally, there was a lack of documentation indicating that the patient had undergone recent imaging or electrodiagnostic testing with findings supportive of the objective clinical examination of the patient. Given the above, the request for a lumbar caudal ESI under fluoroscopy and IV sedation CPT codes 62311 and 77G03, is non-certified."*

On July 25, 2013, noted that over a year ago the patient had gotten more than 70% improvement in his back, buttock and leg pain allowing him to be more functional at home and in the community. He was able to stand for longer periods of time. He was able to take less medicine. The patient felt that this pain particularly down his left leg had become bothersome with associated numbness, weakness and tingling. He did have a positive SLR sign on the left. He did have decreased pinprick sensation in the L5 distribution. He was utilizing Norco four times per day, Wellbutrin 150 mg b.i.d. and gabapentin. He wanted to go ahead with caudal epidural blockade. He stated he was not even able to sleep now on the Ambien, which was a non-end drug. As a result, caudal epidural blockade had been advised. recommended arranging for pending insurance authorization.

Per reconsideration review dated August 12, 2013, the request for lumbar caudal ESI under fluoroscopy and IV sedation CPT 62311, 77003 was denied with the following rationale: "*The Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Pain details for ESI that, "Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)." The notes indicated that, on physical examination, the patient had a positive SLR on the left and decreased pinprick sensation at the L5-S1 distribution. Additionally, the notes indicated that the patient failed conservative rehabilitative and medical treatment options. However, there were no notes submitted with documentation to review to assess the dates of service (DOS), duration and/or efficacy of previous conservative care; in addition, there was no rationale to support the need for sedation. Therefore, the request for a lumbar caudal ESI under fluoroscopy and IV sedation is given a recommendation of adverse determination."*

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
The patient has ongoing axial and radicular pain. The request for ESI clearly meets the criteria for ODG, as conservative care has been tried and the patient has neurological signs and symptoms stemming from spine disorder.

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

ODG – epidural steroid injections

Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. [NOTE: This treatment for Low back & Neck pain is primarily covered in those respective chapters.] Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. See the Low Back Chapter for more information and references. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three". Also see the Neck and Upper Back Chapter.

*Sedation:* There is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. This is of particular concern in the cervical region. (Hodges 1999) Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. The general agent recommended is a benzodiazepine. (Trentman 2008) (Kim 2007) (Cuccuzzella 2006) While sedation is not recommended for facet injections (especially with opioids) because it may alter the anesthetic diagnostic response, sedation is not generally necessary for an ESI but is not contraindicated. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. Supervision services provided by the operating physician are considered part of the surgical service provided.

**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, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.*

1) Radiculopathy must be documented by physical examination and 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) for guidance.
4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) 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 to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)
8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.
9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block.