

# Medical Assessments, Inc.

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## Notice of Independent Review Decision

October 23, 2014

### **IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Caudal Epidural Steroid Injection using Fluoroscopy

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

The Reviewer is a Board Certified Orthopaedic Surgeon with over 13 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.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was injured on xx/xx/xx leading to hurting his left shoulder, left elbow and lower back.

06/10/2014: Evaluation. **Complaints:** Pt has numbness not as much though. Pain is still radiating down left arm from left shoulder. Popping and crunching in left shoulder. Constant discomfort in left elbow. Certain movements and bends cause sharp pain in left elbow. Pain scale 4/10. Stated back feels the same. Pain scale 8/1. **X-rays: Left Shoulder 2 views:** (internal and external rotation) X-rays were negative for fracture or dislocation. **Left Elbow:** 3 views were negative for fracture or dislocation. **Lumbar Spine:** 2 views were negative for fracture or dislocation. **Recommendations:** Continue PT, Medications: Naprosyn 500mg, Flexeril 10mg. Continue light duty.

06/13/2014: MRI of Lumbar Spine. **Impression:** 1. There are facet joint effusions at all lumbar levels, indicative of acute facet joint irritation and lumbar facet syndrome. 2. L1-2, L2-3, and L3-4: No evidence of disc herniation, Thecal sac stenosis, or neural foraminal encroachment. 3. L4-5: 1mm retrolisthesis and a 1 mm central disc protrusion. 4. L5-S1: 1.5 MM retrolisthesis and evidence of prior laminal resection and presumed discectomy. There is a broad 2mm band of posterior annular soft tissue which enlarges to 5mm within the central and left paracentral area causing posterior displacement of the left S1 nerve root and mild bilateral neural foraminal narrowing. The annular soft tissue could present an enhanced images could differentiate these possibilities if necessary. There is mild bilateral neural foraminal narrowing at this level as well.

06/17/2014: Evaluation. **Complaints:** Claimant reported arm is still in pain, has numbness and tingling. Lt elbow still has discomfort. Pain scale all around 4/10. Stated low back pain is still the same. **Recommendations:** Continue PT.

06/27/2014: Evaluation. **HIP:** Claimant was referred for evaluation of right sided lumbosacral pain with some radiation into the groin. He actually ended up injuring his left shoulder but now has additionally developed right lumbosacral pain radiating toward the groin. He does not have radicular pain like he had 4 years ago when I did a left sided L5-S1 laminectomy discectomy. Since the injury he's done PT and has been taking Aleve and Flexeril. He reports that he has some paresthesias into the groin which were not present before the event. He also reports discomfort in the buttock and some into the lateral thigh. Pain level 7/10. **Medications:** Aspirin, Omeprazole tbec, Toprol XL XR24H. **PE:** Right Psoas strength is 5-. Left Psoas strength is 5. Quadriceps are normal. Tib Anterior's are normal. EHL.Peroneus's are normal. Gastro-Soleus are normal. Lower extremities reflexes are symmetrically present and normal. Light touch is normal for all lumbar dermatomes. Patient demonstrates non-tender, active, passive and unrestricted ROM of the hips, knees, ankles and feet. There is no lymphedema of the lower extremities or cyanosis of the toes. Normal muscle tone. Fortin Finger test is positive to the right. **Plan:** Discussed the option of a sacroiliac joint block for both diagnostic and therapeutic purposes.

07/22/2014: Operative Report. **Postoperative Diagnosis:** 1. Lumbar spondylosis without myelopathy. 2. Right sacroiliac joint strain syndrome. **Procedure:** Right sacroiliac joint injection.

09/04/2014: Evaluation. **HIP:** Claimant reported the injection did help but it did not completely eliminate his pain. Review of his postprocedure pin log shows that his pain level decreased from a 7 to a 4 within an hour after the injection. He reports an intermittent lower extremity radicular pain and paresthesias, now noticeable on the left side. Pain left today 6/10. **PE:** Lower extremities strength is symmetrically present in all lower extremity muscle groups. **Plan:** Based upon his improvement during the anesthetic phase of the SI Joint block, I do think the SI joint is contributing to his symptomatology. It clearly is not all of his pain but approximately half of it. I suspect that the remaining portion of his pain relates to degenerative changes at the L5-S1 level and possibly also the L4-5 level. He's

interested in an epidural injection which I will arrange. I will have him follow up after the injection to decide whether to continue with epidural injections or consider rhizotomy for the SI joint

09/24/2014: UR. Rationale for Denial: At the present time, for the described medial situation, Official Disability Guidelines would not support this specific request to be one of medical necessity. This reference would not support this request to be one of medical necessity as a past lumbar MRI did not reveal any findings worrisome for a compressive lesion upon a neural element in the lumbar spine. Additionally, the records available for review do not document the presence of radicular symptoms. As such, presently, per criteria set forth by the above noted reference, medical necessity for this specific request is not established.

10/09/2014: UR. Rationale for Denial: The patient is a male who sustained an injury on xx/xx/xx. The patient underwent L5-S1 left-sided laminectomy discectomy in 2010. The patient had a right sacroiliac joint injection on 7/22/2014, which helped but did not completely eliminate the pain, and decreased the pain from a 7 to a 4 within an hour after the injection. The patient had been treated with PT and medication. The patient had an S1 injection with minimal relief. There was persistent back and leg pain. There are no reflex, motor or sensory changes on exam to indicate objective signs of radiculopathy. While the patient has failed conservative therapy, there is no documentation of radiculopathy as required by ODG guidelines. Therefore, the request for a caudal epidural steroid injection using fluoroscopy is not medically necessary or appropriate.

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

The patient does not require a caudal epidural steroid injection using fluoroscopy.

The Official Disability Guidelines (ODG) supports epidural steroid injections (ESI) for the treatment of radiculopathy due to a herniated disc. The radiculopathy should be documented with objective physical examination findings and supported by imaging studies and/or electrodiagnostic testing.

The patient has no objective evidence of radiculopathy in the records reviewed. He has no weakness, sensory deficits, or abnormal reflexes consistent with compression of a specific nerve root. He has no physical findings that correlate with the L5-S1 disc pathology identified on MRI.

The requested ESI is not medically necessary for this patient.

## 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 (due to herniated nucleus pulposus, but not spinal stenosis) 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)**