

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: May 29, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Caudal ESI (L5-S1)

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

This physician is a Board Certified Orthopedic 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He felt a "pop" in his left ankle. He reported the injury and continued to work. About a week later, he exacerbated it. Immediately afterward, he felt low back pain with radiation into the left leg. The claimant was initially seen. MRI of the left lower leg and lumbar spine were ordered. The claimant was placed in physical therapy.

On November 21, 2013, MRI of the Lumbar Spine, Impression: 1. High signal intensity zone in the posterior aspect of the annulus at L1-2, L2-3, L3-4, L4-5 levels with multiple disc protrusions as described above. 2. Central and left sided disc protrusion at L4-5 level with obliteration of epidural fat and impingement on thecal sac. 3. Congenitally small central spinal canal throughout the spinal canal further complicated by disc protrusion, thickening of ligamentum flavum, facet

arthropathy. 4. Abnormal signal intensity and density involving the region of the conus in the anterior aspect which needs further evaluation of the MRI of the thoracic spine with and without contrast enhancement.

On January 13, 2014, the claimant presented with constant sharp, shooting pain in his left leg and lumbar spine. Pain was rated 7-8/10. I was reported the claimant did undergo 8 sessions of physical therapy between 9/26/13 and 10/24/13. On physical examination ROM in the lumbar spine was restricted. Muscle testing revealed weakness in the left lower extremity 4/5. Kemp's Test on the left was positive and SLR on the left was positive. Palpatory pain was noted in the left leg and lumbar and SI para spinal muscles. Sensory function was observed to be normal. Reflexes were 2+ on the right for Patellar, Medial Hamstring and Achilles, 1+ on the left for Patellar, Medial Hamstring and Achilles. Plan: Schedule for an FCE, refer for a neurosurgical consult, possible candidate for a return to work program.

On April 16, 2014, the claimant presented with low back and left leg pain. It was reported his pain was getting progressively worse. It was worse at night and was waking him from sleep. He had difficulty with standing, walking, lying down and physical activity. He was reported to have been treated with chiropractic and physical therapy. Medications included Aleve, Ibuprofen, Ultracet 37.5/325 mg, Zanaflex 4 mg, Celebrex 200 mg, and Medrol Pak 4 mg. On physical examination he demonstrated a normal gait pattern. There was significant spinal tenderness in the paraspinal muscles. Bilateral straight leg raise was negative. There were no Waddell sign's present. There was normal sensation to light touch seen in both upper and lower extremities. There was normal motor strength to upper and lower extremities. Reflexes in upper and lower extremities were normal at 2/4. There was negative Spurlings test and negative Lhermitte's sign. He demonstrated limited range of motion with flexion, extension, side bending and rotation. Spinal motion was with pain. X-rays performed in the office showed normal appearance to the Sacroiliac joints, normal appearing vertebral bodies, no instability seen, normal appearance to the discs and there were changes seen in the disc spaces L2-S1. Diagnosis: Multilevel degenerative changes from L2-S1, with congenital spinal stenosis. Plan: Prescribe Medrol Dosepak, Celebrex, Zanaflex and Ultracet. Recommend lumbar ESI.

On April 24, 2014, UR. Rationale for Denial: ODG guidelines recommend ESI's as an optional treatment for radiculopathy. Radiculopathy must be documented with objective findings on exam that are corroborated by diagnostic testing. MRI did not show specific nerve compromise. The physical exam was devoid of objective evidence of radiculopathy. Straight leg raise was noted to be negative. The request does not meet ODG criteria for an ESI.

On May 6, 2014, UR. Rationale for Denial: ODG does not support epidural injections in the absence of objective radiculopathy. In addition, ODG criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology; and conservative treatment. Furthermore, repeat blocks should only be offered if there is at least 50-70% pain

relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. However, there was no new information provide on this appeal request. There is no evidence of objective radiculopathy on the most recent physical examination. It is unclear if the patient has ever had a lumbar ESI previously. Recommend adverse determination.

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

The previous adverse determinations are upheld. A caudal epidural steroid injection (ESI) is not indicated in this claimant. The Official Disability Guidelines (ODG) supports ESI when objective physical findings are consistent with lumbar radiculopathy. Imaging studies and/or electrodiagnostic studies should support the diagnosis of radiculopathy associated with a herniated disc.

The claimant is currently complaining of pain in the lower back and left leg. The April 2014 examination indicates no evidence of radiculopathy. The claimant has no weakness or sensory deficits in the lower extremity. He has a negative straight leg raise sign. His MRI study does not demonstrate nerve compression by an intervertebral disc at the neural foramen. Therefore, the proposed Caudal ESI (L5-S1) does not meet the requirements of the ODG criteria and is found to be not medically necessary at this time.

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 (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. (Doi

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)**