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Notice of Independent Review Decision

DATE: September 10, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Caudal Epidural Steroid Injection at L5-S1 62311, 72275.26

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

The reviewer is certified by the American Board of Orthopaedic Surgery with over 42 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 injured his low back when he fell on xx/xx/xx.

04/25/11: Operative report. POSTOPERATIVE DIAGNOSIS: Severe degenerative disc disease with internal disc derangement L4-L5, L5-S1 with HNP at L4-L5, L5-S1. PROCEDURES: 360-degree fusion at L4-L5 and L5-S1.

10/12/11: The claimant was evaluated who stated that he was doing well.

06/17/13: Operative report. POSTOPERATIVE DIAGNOSIS: Hardware pain with possible pseudoarthrosis. PROCEDURES: Removal of pedicle screw instrumentation, L4-S1. Exploration of fusion, L4-S1. Revision posterior fusion L4-S1 using allograft bone with bone marrow aspiration. Bone marrow aspiration x 3.

07/17/13: The claimant was evaluated for postop hardware removal at L4-L5 and L5-S1. His exam was normal. His incision was well healed. He stated that the

surgery helped for the first three weeks, but then his pain flared up. noted that it "sounds more of the inflammatory at this point." He was given a Medrol Dosepak and Celebrex and was to start PT.

09/18/13: The claimant was evaluated. He stated that he was doing much better and had significant reduction in his pain. He had not started PT. He was given a prescription for Celebrex and was to start PT.

10/22/13: Progress note indicated that had completed 11/12 visits. He was still having back and right hip pain but reported the pain was less than when he started PT. He also appeared to be able to move better without increases in pain. Atrophy was noted in the right gluteal region. He was to continue with PT for six weeks.

01/08/14: The claimant was evaluated. He was wanting to go back to work, and he was released for the same. He was noted to still have some pain, but he felt it was manageable. He was given pain cream. He was to take his brace with him as he went back to work.

04/16/14: The claimant was evaluated for severe pain in the low back. His medications included Lyrica, Tizanidine, Norco, Medrol, and Celebrex. He rated his pain as 7 to 9, particularly while working. He stated that his pain had been increasing and had also started to radiate down into his right leg. On exam, he had significant tenderness over the L4 to S1 level. He had very limited motion with flexion and extension. Imaging studies were ordered. He was given a prescription for Lyrica, hydrocodone, Zanaflex, and etodolac. He was diagnosed with hypertension, low back pain, and painful hardware or graft.

05/12/14: MRI lumbar spine without contrast report interpreted IMPRESSION: Subligamentous T12-L1 and L1-L2 central disc protrusions appearing in the interim since the previous exam produce small extradural indentations upon the anterior thecal sac at T12-L1 and L1-L2. Status post a prior anterior and posterior L4-L5 and L5-S1 arthrodesis. Residual osteoarthritic ridge formation produces a borderline stenosis of the left L5-S1 neural foramen and mild intra-foraminal L5 nerve root compression. No HNP, foraminal stenosis, or graft migration produces extradural neural impingement on the right.

05/21/14: The claimant was evaluated who noted that he had issues of pain in his back and radiating into the leg. There was no documented exam. noted that he could have some radiculopathy secondary to inflammation. He recommended an epidural steroid injection.

07/22/14: UR. RATIONALE: There was no indication from the available documentation/information of any specific objective lumbar radiculopathy pattern occurring at a particular level based on the physical examination finding sand correlated with the work-up done. Rather, there were no detailed objective physical examination findings listed at all with regard to the low back and lower

extremities that would support the need for caudal epidural steroid injection. There was also mention of the patient having a painful hardware condition and not clear whether the pain source has been completely ruled out and not clear why an epidural injection would be required if there was already painful hardware present. There was also no indication of a radiculopathy occurring from the diagnostic workup done including MRI imaging in which there was no mention of a herniated nucleus pulposus present that was impingement upon a nerve root that would support the need for the ESI. Also, there was no documented electrodiagnostic study that clarifies whether an objective lumbar radiculopathy is occurring or not as well at a particular level to support the need for the ESI. Therefore, this request is not medically reasonable or necessary.

08/20/14: UR. RATIONALE: We recommend no more than two ESI injections for the initial phase and rarely more than two for the therapeutic treatment with no examination findings supporting a radiculopathy. There were no exam findings supporting radiculopathy by deficits in deep tendon reflex, motor or sensory. The medical necessity has not been established within these guidelines.

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

The previous adverse decisions are upheld. The provided records do not indicate a radicular component to the claimant's back complaints. While he complains of leg pain, this is not noted on exam. There is no mention of positive straight leg raise maneuver or other stretch tests on exam. There are no positive signs on exam of radiculopathy. There are no reflex changes, weakness, atrophy noted. The ODG criteria have not been met. Therefore, the request for Caudal Epidural Steroid Injection at L5-S1 62311, 72275.26 is not medically necessary.

ODG:

<p>Epidural steroid injections (ESIs), therapeutic</p>	<p>Criteria for the use of Epidural steroid injections: <i>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.</i></p> <p>(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.</p> <p>(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).</p> <p>(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.</p> <p>(4) <i>Diagnostic Phase:</i> 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</p>
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	<p>injections.</p> <p>(5) No more than two nerve root levels should be injected using transforaminal blocks.</p> <p>(6) No more than one interlaminar level should be injected at one session.</p> <p>(7) <i>Therapeutic phase:</i> 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)</p> <p>(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.</p> <p>(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.</p> <p>(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.</p> <p>(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.)</p>
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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)