CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: August 25, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Prospective Lumbar Spine L5/S1 Caudal Epidural Steroid Injection (ESI) including CPT codes 62311 and 72275.26

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He was seen in the ER about a week later where CT scans of the head, neck and low back were performed. He was also prescribed Tramadol.

On xx/xx/xx, CT of the Lumbar Spine, Impression: Mild lumbar spondylosis. No acute bony injury.

On February 28, 2014, the claimant was evaluated for back and leg pain. He reported trouble getting around with limping sometimes when his leg gave out. He felt unsecure walking. On physical examination he had a limp. He had tenderness in the low back involving both sides, midline and more to the left. He

had mild muscle spasm. Flexion and extension was markedly limited with pain on rotation as well. Reflexes of the lower extremities were intact. Straight leg raise was limited to about 45 degrees bilaterally because of pain. There was not much atrophy. Sensation was decreased in the feet compared to the lower leg bilaterally. Medications included gabapentin 300mg, tramadol 50 mg, and Wellbutrin 5R 150 mg. Plan: MRI lumbar spine.

On March 3, 2014, MRI of the Lumbar Spine, Impression: 1. Edema within the pedicle and pars interarticularis on the right at L5. Questioned stress injury. 2. Mild lumbar spondylosis. No canal or neural foraminal encroachment.

On March 6, 2014, the claimant was re-evaluated for pain going down the leg. It was reported the gabapentin made him sick, so it was discontinued and he was started on Lyrica 50 mg twice a day. Tramadol was renewed and he was started on Naproxen. He was also referred to the Institute.

On March 28, 2014, the claimant was evaluated for low back and leg pain. 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 signs 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 were normal at 2 out of 4. There was negative Spurlings test and negative Lhermitte's sign. He demonstrated good range of motion, but with pain. Recommendation: 6-8 weeks of PT and Medrol Dose pack, a non-steroidal anti-inflammatory, a muscle relaxer, and pain medication. EMG of the lower extremities. He was also given a neuromuscular stimulator to help with pain and muscle spasms.

On May 7, 2014, EMG/NCS of the lower extremities, Impression: 1. There is electrodiagnostic evidence of chronic bilateral L5 lumbar radiculopathy of mild severity. 2. The attenuated left tibial H-reflex may possibly indicate left S1 radiculopathy. Clinical correlation is recommended, as electrophysiological evaluation of these waves may provide the earliest means of detecting abnormalities of root disease. 3. There is no evidence of sacral plecopathy, focal peroneal or tibial neuropathies in their knee or ankle segments, lateral plantar neuropathies in their ankle or foot segments, lower limbs large fiber peripheral polyneuropathy, neuromuscular transmission defects, or myopathy.

On May 23, 2014, the claimant was re-evaluated. No physical examination was provided. Based on the electrodiagnostic results showing radiculopathy, recommended an epidural steroid injection.

On June 6, 2014, UR. Rationale for Denial: There is no recent detailed physical examination of the lumbar spine provided for review. The ODG states that radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. An EMG/NCV study dated 05/07/2014 revealed mild L5

radiculopathy; however, MRI and CT scan of the lumbar spine did not reveal any significant radicular pain generators. There was no physical examination to correlate these findings. The ODG states that the claimant must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). There were no physical therapy notes provided for review that would indicate the amount of physical therapy visits that the claimant has completed to date or the claimant's response to any previous conservative treatment. Given the clinical documentation submitted for review, medical necessity of the perspective request for lumbar spine L5-S1 caudal epidural steroid injection including CPT codes 62311 and 72275.26 has not been established.

On July 28, 2014 UR. Rationale for Denial: Guideline criteria have not been met as there is no objective evidence of radiculopathy clinically.

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

The previous adverse determinations are upheld. The patient is not indicated for a lumbar spine L5/S1 caudal epidural steroid injection (ESI).

The Official Disability Guidelines (ODG) support epidural steroid injections for the treatment of lumbar radiculopathy associated with a disc herniation. The imaging studies should correlate with objective findings of radiculopathy on physical examination.

The patient's physical examination of March 28, 2014 demonstrated no evidence of radiculopathy. The patient had no weakness, sensory deficits or abnormal reflexes. His straight leg sign was negative bilaterally. The lumbar spine MRI identified mild lumbar spondylosis without neuroforaminal stenosis. The EMG/NC study documented mild L5 radiculopathy, which did not correlate with the physical examination.

Therefore, the request for Prospective Lumbar Spine L5/S1 Caudal Epidural Steroid Injection (ESI) including CPT codes 62311 and 72275.26 does not meet ODG criteria and is denied.

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. (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)**