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Notice of Independent Review Decision

January 6, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Caudal epidural steroid injection (ESI)

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

Pain Management Physician

REVIEW OUTCOME:

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

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 patient is a female who slipped and fell on a waxed floor on xx/xx/xx.

On November 25, 2008, magnetic resonance imaging (MRI) of the lumbar spine showed mild disc bulge at L3-L4 with a small focal central protrusion, mild facet arthropathy, mild ligamentum flavum thickening and mild right foraminal stenosis. At L4-L5, there was a mild disc bulge, a broad-based central and left central disc protrusion which was small but came in close proximity to the traversing left L5 nerve root. There was mild facet arthropathy bilaterally and mild ligamentum flavum thickening. There was mild bilateral foraminal stenosis. At L5-S1, there was mild disc bulge, a small central and right central disc protrusion coming in close proximity to the right S1 nerve root. There was mild facet hypertrophy and moderate left and mild-to-moderate right foraminal stenosis.

An MRI of the cervical spine dated November 25, 2008, showed degenerative disc space narrowing at C6-C7 with a 3 mm central spur displacing the CSF ventral to the cord and abut the ventral aspect of the cord. There was associated spurring into the intervertebral foramina bilaterally with moderate bilateral bony foraminal narrowing, right more than left. There was mild central spinal stenosis at this level. At C5-C6, there was degenerative disc space narrowing with a 3.5 mm central spur displacing CSF ventral to the cord and impinging upon the ventral aspect of the cord. There was a paucity of CSF dorsal to the cord indicating mild-to-moderate intervertebral foramen with marked narrowing of the right intervertebral foramen which could affect the exiting right C6 root. At C4-C5, there was a 3-4 mm right-sided posterolateral spur abutting the right ventral lateral aspect of the cord and projecting into the right intervertebral foramen causing marked narrowing of the right intervertebral foramen affecting the exiting C5 root.

No records are available for 2009.

On January 7, 2010, electromyography/nerve conduction velocity (EMG/NCV) of the upper extremities showed active right C6 radiculopathy (no significant change from 03/09 study) and mild bilateral median neuropathy at the wrist.

On March 8, 2010, an MRI of the lumbar spine showed broad-based posterior disc protrusion at L3-L4 measuring 5-6 mm to the left of midline and 7 mm to the right of midline. There was central canal narrowing with an AP diameter of 8-9 mm. There was 5 mm broad-based posterior protrusion at L4-L5 causing impression on the anterior thecal sac slightly greater to the left of midline. There was 5-6 mm broad-based ventral defect at L5-S1 most likely related to posterior osteophytes. A laminectomy had been performed at this level. There was slight impression on the anterior thecal sac. Disc and spur extended into the inferior margins of the neural foramina bilaterally causing narrowing with the left side more involved than the right. There could be some compromise of either L5 nerve root. There was disc desiccation from L3-L4 through L5-S1 with disc space height loss at L3-L4 and L5-S1. There was slight scoliosis of the lumbar spine convex to the left.

On March 8, 2010, an MRI of the cervical spine showed 4 mm broad-based ventral defect at C5-C6 representing disc and/or spur deforming the anterior spinal cord without direct cord contact resulting in severe central canal narrowing. There was a questionable disc fragment behind C5 vertebral body to the right of midline on one of the sagittal sequences. There was moderate left and mild right neural foraminal narrowing. There was a 3 mm broad-based ventral defect at C6-C7 most likely a disc protrusion. There was deformity of the anterior spinal cord without direct cord contact and narrowing of the central canal to 7-8 mm. There was severe right and moderate severe left neural foraminal narrowing. There was severe narrowing of the right neural foramen at C4-C5 related to 3 mm right paracentral/uncinate spurs and very mild narrowing of the left neural foramen. There was tiny disc protrusion or spur at C3-C4. There was linear focus of T2 hyperintensity within the spinal cord at C2 representing either some slight dilatation of the intramedullary canal or a very small syrinx.

On May 28, 2010, computerized tomography (CT) of the cervical spine showed 3-4 mm broad-based ventral defect at C5-C6 representing posterior osteophyte with partially calcified underlying disc causing impression on the anterior thecal sac greater to the right of midline. There was suggestion of some partially calcified disc material extending behind the right sides of the C5 and C6 vertebral bodies. Some calcification of the ligament was felt to be less likely. There was moderate severe central canal narrowing. There was moderate right and mild left neural foraminal narrowing. A combination of disc and spur noted posterior at C6-C7 measuring approximately 3 mm causing moderate central canal stenosis. There was moderate severe right and moderate left neural foraminal narrowing. There was posterolateral projecting osteophytes at C4-C5 measuring 3 mm to the right and 1-2 mm to the left. There was deformity of the right anterior aspect of the thecal sac. There was moderate severe right and moderate left neural foraminal narrowing. There was 2 mm posterior central disc protrusion at C3-C4 and mild central canal narrowing at this level.

On December 15, 2010, performed right L4 and L5 transforaminal ESI.

On April 18, 2011, noted the patient was doing better since surgery and did not need hydrocodone but wanted to go back to the Ultram ER. prescribed Ultram ER and refilled Relpax. The patient reported ongoing neck and arm pain and some low back pain. She was released to work.

On October 21, 2011, noted some recurrence of neck and arm pain and her low back pain was as before. She reported electrical charge, a kind of stabbing pain at the base of the neck. Examination revealed decreased sensation involving the right lateral foramen and the thenar eminence on the right. There was decreased biceps, triceps and deltoid strength on the right. There was decreased sensation involving the right posterolateral leg. The EHL strength was decreased on the right compared with the left. Sitting root test was positive on the right. Lhermitte maneuver on her neck was positive on the left. Spurling maneuver gave some upper thoracic and rhomboid pain and one the right was more localized pain. reported the patient had fusion from C4 to C7. She had responded nicely to epidural injections before. He prescribed Medrol Dosepak, refilled Relpax, Soma, Celebrex, Ultram and Norco and opined the patient might need to be restudied and might need more injections.

On April 18, 2012, noted Medrol Dosepak did not help. The pain levels were virtually same as last time. She had A&P repair on April 5, 2012. diagnosed cervical radicular syndrome and lumbar radicular syndrome. He recommended lumbar ESI on the right.

On May 2, 2012, noted that ESI was denied. He resubmitted the request for lumbar ESI.

On May 15, 2012, performed right L3-L4 transforaminal ESI.

On August 27, 2012, noted that ESI worked great and the patient went back to work. The patient had recurrence of the right lumbar pain of the right leg and right neck pain in the right arm. The neck was worse than the low back. Examination revealed abnormal left light touch at C6, C7 and T1. refilled medications and recommended cervical and lumbar ESI.

On October 18, 2012, noted the request for cervical and lumbar ESI had been denied. The patient had pain in the neck into the right arm in a C5-C6 distribution. Examination revealed abnormal right pinprick at C6 dermatome. There was positive Spurling's on the right and positive Lhermitte's sign. diagnosed cervical radicular syndrome and recommended C5-C6 ESI and gave Dilaudid.

On November 8, 2012, noted ongoing back and neck pain. ordered repeat MRI of the cervical and lumbar spine.

On March 11, 2013, noted the patient still had electrical discharges in the right side of her neck and into the right arm. There was numbness in the left great toe. refilled Celebrex, Ultram, and Relpax and prescribed hydrocodone-acetaminophen.

On September 10, 2013, noted recurrent right neck pain into the right rhomboids and headaches. recommended L4 and L5 transforaminal ESI on the right. He prescribed methadone and opined that she could use Flexeril.

On October 8, 2013, performed a caudal ESI.

On January 28, 2014, noted the patient was doing much better in terms of her neck and her arm. She reported that lumbar epidural was very helpful but pain had returned. Methadone caused memory loss and headaches. Examination revealed tender paravertebral muscles bilaterally. Lumbar range of motion (ROM) was painful and restricted to flexion and extension. Straight leg raising (SLR) was positive on the right at 75 degrees and on the left at 90 degrees. Left light touch was abnormal at L5 and S1 dermatomes. discussed epidurals versus facet injections.

On March 4, 2014, performed a caudal ESI.

On April 15, 2014, noted increased right arm pain. There was recurrent right leg pain. The recent ESI had not helped low back and leg. Her primary doctor had put her on Neurontin and Lexapro. Examination revealed the patient was sitting uncomfortably. She had difficulty acquiring a full, upright position when getting out of the chair. She was stooped forward and gait was antalgic to the right. Levator scapulae, trapezius, scalenus muscles were tender on the right. Spurling's was positive on the right and Lhermitte's sign was positive. The paravertebral muscles were tender on the left. Lumbar ROM was painful and restricted. SLR was normal bilaterally. The right light touch was abnormal at C6 dermatomes and left light touch was abnormal at C6 dermatomes. Right light

touch was abnormal at L5 and S1 dermatomes. refilled Soma and recommended L4-L5 facet injection on the left and C6 transforaminal ESI on the right.

On May 7, 2014, performed left L4-L5 facet joint injection and right C6 selective nerve root block.

On June 4, 2014, noted the patient had relief of her left low back pain. The patient still had right leg pain that was getting worse. The C6 transforaminal injection on the right helped for about 3 weeks but pain came back. The patient reported she was ataxic and running into walls like she was before her neck surgery a few years ago. ordered MRI of the cervical and lumbar spine.

On June 27, 2014, an MRI of the lumbar spine showed mild central canal stenosis at L3-L4 related to a 6 mm combination of disc and spur with degenerative facet joint changes. There was moderate narrowing of the right neural foramen. There was interval worsening in the caliber of the right neural foramen. There was 5 mm diffuse annular bulge at L4-L5 with degenerative facet joint changes causing borderline central canal narrowing. There was moderate left and mild right neural foraminal narrowing. There was slight interval worsening in the caliber of the left neural foramen. There was 5 mm posterior osteophytic spur at L5-S1 slightly exceeding the bony margins. There was no central canal stenosis. There was severe left and mild right neural foraminal narrowing. The findings were similar to the prior study. There was slight scoliosis of the lumbar spine convex to the left.

On June 27, 2014, an MRI of the cervical spine showed interval performance of the anterior cervical fusion from C4-C7 with signs suggestive of solid fusion at C4-C5 and C5-C6. There was interval improvement in the caliber of the central canal at C4-C5 and C5-C6. There was moderate central canal stenosis again noted at C6-C7. There was interval retrolisthesis of C3 on C4 with 3-4 mm posterior disc protrusion deforming the anterior spinal cord and narrowing the central canal to 8 mm. There was moderate severe right and moderate left neural foraminal narrowing. There was multilevel neural foraminal narrowing. There was subtle linear focus of T2 hyperintensity within the spinal cord at the C2 representing some dilatation of the intramedullary canal or small syrinx. This was unchanged.

On July 24, 2014, reviewed the MRI. The patient reported her low back was doing a little bit better. She had significant neck pain and ataxia. The pain radiated into the right deltoid. recommended ESI.

On August 13, 2014, performed right C3-C4 selective nerve root block.

On October 2, 2014, reported her cervical ESI had worked beautifully. She had relief for about six weeks and then slowly started coming back. The arm pain and headaches were relieved dramatically. She was complaining more of stabbing pain in the lower back in the posterior right thigh. The patient had trouble opening jars with the right hand. She was dropping cooking utensils. Examination revealed tender paravertebral muscles on the right, painful and restricted lumbar ROM and pain with seated SLR that was located at back, buttock and thigh. Right

light touch was abnormal at L5 and S1 dermatomes. recommended transforaminal ESI at L5-S1 on the right, gave oxycodone and refilled Soma.

On November 25, 2014, noted that the patient had epidural injection on November 4, 2014 at L5-S1 on the right. Unfortunately it did nothing for her. The patient had pain into the lateral aspect of the right leg more consistent with an L5 distribution. felt the patient might need injection at L4-L5. The patient reported oxycodone made her angry, Dilaudid caused itch and methadone altered her sensorium. Lidoderm patches helped. Examination revealed the patient sitting uncomfortably, she had difficulty acquiring a full, upright position when getting out of the chair and gait was antalgic to the right. Paravertebral muscles were tender bilaterally, SLR was positive on the right at 75 degrees and there was pain with seated SLR that was located at back, buttocks and thigh. SLR was positive on the left at 75 degrees and she had pain with seated SLR located at back. Cross leg test was positive. gave morphine sulfate IR and ordered caudal ESI.

Per utilization review dated December 4, 2014, the request for caudal ESI was denied based on the following rationale: *“Review on previous records noted a caudal ESI on March 4, 2014 was not helpful at all, thus there is not sufficient documentation or rationale for a caudal ESI, thus the request is not approved”*.

Per reconsideration review dated December 15, 2014, the appeal for caudal ESI was denied based on the following rationale: *“EMG shows no lumbar radiculopathy. Claimant has had previous caudals October 13, 2014 and March 4, 2014, both of which were not helpful. Claimant had caudal September 12, 2013, with no results reported. Both of these used fluoroscopic confirmation. called at 1515 hrs. I went over findings on MRI and explained to him that I even went back and looked at the two injections that did not work but they had been fluoroscopically verified so at this point I could not find any reason to reverse the prior decision. He understood.”*

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

According to the ODG criteria for ESI:

Diagnostic phase: a second block is not indicated unless: A. there is a question of the pain generator; B. there was possibility of inaccurate placement; C. there is evidence of multilevel pathology. In these cases, a different level or approach may be proposed.

Therapeutic phase: If after the initial block/blocks are given and found to produce pain relief of 50-70% for 6-8 weeks, additional blocks may be required. Indications of for repeat blocks include acute exacerbation of pain, or new onset of symptoms. The general consensus is no more than 4 blocks in a year.

The patient meets the criteria for additional blocks, however, not at the caudal approach. Claimant has had previous caudal epidural steroid injections October 13, 2014 and March 4, 2014, both of which did not provide 50-70% relief for 6-8 weeks. Thus, the prior decision is upheld.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES