

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: December 14, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LESI L5-S1 Caudal

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

This physician is Board Certified in Anesthesiology with over 12 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]:

07-10-09: MR Lumbar Spine w/o contrast 72148. Impression: 1. Loss of lumbar lordosis with anterior-posterior fusion L4-S1 and posterior decompression at L4 and L5. No evidence of complication by MRI at this level. 2. Multilevel listhesis at the mid lumbar spine with annular tear L2-3 and findings suspicious for annular tearing L4-5. 3. Broad-based 2 mm disc protrusion at L2-3 with mild bilateral recess narrowing without central nerve root impingement. There is mild central canal narrowing. 4. Retrolisthesis and 1.5 mm broad-based disc bulge at L3-4 with a right foraminal 5 mm disc herniation. There is contact of the left L4 nerve root. Moderate to severe right and moderate left neuroforaminal narrowing. There is contact of the right exiting L3 nerve. Moderate central canal narrowing. 5. Widely patent neuroforaminal and central canal at L4-5 and L5-S1.

06-11-11: CT Neck without Contrast. Impression: Essentially normal CT scan of the neck. Mild spondylitic changes of the cervical spine.

06-25-13: Office Visit. CC: low back pain, here for Lumbar caudal steroid injection. Claimant was last seen on 3/28/13 for evaluation of low back pain and foot pain, described as constant, aching, burning, dull, sharp, shooting and stabbing. The current location of her pain is primarily in the lower bilateral lumbar spine and both feet. The pain also radiates to the right buttock and the right lower extremity involving the lateral thigh, posterior thigh, and groin, 7/10 pain. She noted some temporary relief with massage, rest, position change, and lying down, medication. The pain worsens with staying in one position too long. She stated that the pain is worse since last visit. Medications include Methadone 5mg po TID, Lyrica 50 mg po BID. Procedures: low back pain, caudal ESI, intravenous sedation. Assessment: 724.2 Low back pain, 729.1 Myofascial pain syndrome. Plan: Tolerated procedure well, office visit.

08-07-13: Office Visit. CC: LBP, dull and aching. The pain is located in the lower back and radiates into the left buttock and left lower extremity involving the posterior thigh. Claimant had a left caudal injection that helped with the burning in her feet 100%, resolved burning sensation. She noted she was only taking 1 Methadone until she had a pinch along her left buttock. She will wean back to one daily as tolerated. Of not, oral medication provided >50% relief when needed, pain at 4/10. Claimant stated she has improved since last visit. ROS: Musculoskeletal: positive for back pain, myalgias and arthralgias. Neurological: positive for parasthesia (left lower extremity) and weakness (left lower extremity). Objective: Exams: left lower extremity, myofascial tenderness noted. Bursae ischial bursa and ischial tuberosity. Assessment: 724.2 low back pain, V58.69 patient visit for long term (current) use of other drugs, V58.83 encounter for therapeutic drug monitoring. Plan: follow up in 3-4 months, HEP provided for knee and hip conditioning, UDS was obtained and will be sent for confirmation. At this time, no changes to her medications. Given substantial concern by claimant for addiction to other narcotics, we should continue on the regimen.

03-05-14: Office Visit. CC: low back pain, constant, intermittent, sharp, shooting, dull, aching and stabbing. The location of her pain is primarily in the lower, bilateral, but predominantly left sided lumbar spine. The pain also radiates to the buttocks bilaterally but mostly left sided and both lower extremities equally involving the posterior thighs and with numbness to left leg and toe, 9/10 pain. She noted some pain relief with medication, massage, heat, ice, and positional changes. The pain worsens with staying in one position for too long. Current medications include Methadone 5mg PO TID, Lyrica 50mg PO BID. Claimant feeling 30% better with Medrol dose pak, but then two days later had a fall due to severe muscle spasms. Current problems: cervicgia, encounter for therapeutic drug monitoring, hip pain, lower back pain, lumbar sprain, myofascial pain syndrome, patient visit for long term (current) use of other drugs, Postlaminectomy syndrome, lumbar region, sacroilitis, low back pain. PE: Thoracic: posterior; right iliocostalis thoracis (T10-L2); Lumbar: posterior lumbar; right iliocostalis lumborum (L1-L4); lower extremity: pelvis and buttocks; right gluteus maximus (iliac) (L5, S1, S2) (inf gluteal nerve). Assessment: 724.2 low back pain, V58.69 patient visit for long term (current) use of other drugs, V58.83

encounter for therapeutic drug monitoring. Orders: Flexeril 10mg PO TID PRN muscle spasms. Plan: continue Methadone and Lyrica, start Flexeril, UDS obtained today, follow up in 2-3 months.

10-15-14: Office Visit. CC: low back pain, intermittent, shooting, dull, aching, stabbing, tingling, burning and she noted this varies from day to day. Current location in the lower, bilateral, but predominantly left sided lumbar spine. The pain also radiates to the buttocks bilaterally but mostly to the left sided, both lower extremities equally involving the posterior thighs, and numbness to left leg from thigh to foot, pain 3-4/10. Relief noted with positional changes and worsens with staying in one position to long. The pain is most worse in the evenings. Current medications include Methadone 5mg PO TID and Lyrica 50mg PO BID. ROS: neurological: positive for paresthesias and weakness. Neurological: Sensation: trunk/sacral/LE: diminished touch is noted – medial legs bilaterally. Pain with flexion. SLR + R at 70 degrees/R leg + bowstring. Lumbar myofascial tenderness noted: L4-5, right lumbar paraspinals and gluteal maximus sacral. Left/Right lower extremity: muscle strength and tone: 4/5 knee extension. Assessment: 724.2 low back pain, V58.69 patient visit for long term (current) use of other drugs, V58.83 encounter for therapeutic drug monitoring. Plan: UDS obtained. Given the claimant's worsening lumbar radicular symptoms, we will proceed with a Caudal ESI. She has done well with these treatments previously noting >50% reduction in lumbar pain and 100% relief of lower limb symptoms. Relief from last tx has lasted > 1 year. Lumbar Epidural Procedures: lumbar caudal ESI w/ anesthetic block 62311.

11-18-14: UR. Reason for denial: The claimant has low back pain and underwent laminectomy and discectomy with fusion and hardware (unspecified body part and updated). The claimant had a caudal epidural steroid injection (ESI) (undated), which the claimant had done well, with more than 50 percent reduction in lumbar pain, and 100 percent relief with the lower limb symptoms. It was also documented that there was relief from the last treatment, which lasted for more than 1 year. The documentation provided did have MRI or any diagnostic study to verify pathology. There are no notes from previous epidural steroid injection (ESI) to verify results. The request for lumbar epidural steroid injection (ESI), L5 to S1 caudal is not certified.

11-24-14: UR. Reason for denial: This request was initially a denial decision on 1/18/14 on the basis that there was no available imaging corroborating pathology or notes from the previous epidural steroid injection to verify positive results. In this case, Genex CGT guidelines indicate epidural steroid injection when there is unequivocal evidence of a radiculopathy. Repeat injections are only given if the initial injection provides objective functional improvement and appropriate, temporary, partial relief sustained for at least 3 weeks. ODG states imaging studies and/or electrodiagnostic testing must corroborate radiculopathy. In this case, while it is reported that the last caudal injection provided relief, it is unclear how long this relief lasted. Furthermore, imaging or electrodiagnostic studies are not available for review to corroborate examination. Without corroborating testing

or clear efficacy of previous treatment, this request is not medically supported. Recommend non-certification.

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

The previous adverse determinations are upheld and agreed upon. In order to approve this request there must imaging studies and/or electrodiagnostic testing to corroborate radiculopathy. In this case, while it is reported that the last caudal injection provided relief, it is unclear how long this relief lasted. Additionally, imaging or electrodiagnostic studies are not available for review to corroborate examination. Therefore, after reviewing the medical records and documentation provided, the request for LESI L5-S1 Caudal is non-certified.

Per ODG:

Epidural steroid injections (ESIs), therapeutic	<p>Criteria for the use of Epidural steroid injections:</p> <p><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 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</p>
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	<p>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)**