

# Health Decisions, Inc.

6601 CR 1022

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May 21, 2015

## **IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Caudal Epidural Steroid Injection

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

An American Board Certified Anesthesiologist with 6 years' 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]:**

xx is a female with low back pain. Original injury date was xx/xx/xx. Patient reports that she injured her back lifting a pallet at work. She is a status post lumbar laminectomy in 2001. She completed the requested physical therapy. She also completed a pain program. She is a status post lumbar fusion October 2006. The patient reports that she went back to work in 2003 until her second surgery in October 2006. She was put on disability in 2007.

10/22/12: Initial Evaluation Visit: The patient complained of low back pain. Pain management includes medications (Norco BID, Lyrica 200mg BID, Trazodone 100mg QHS, Seroquel 300mg BID, and Lisiniopril), TENS unit, heat therapy, bedrest and psychotherapy which all have helped some. The patient reported that she had some injections in the past without relief. Exam reveals Positive Midline lumbar scar which is well-healed. Lumbar lordosis is noted to be decreased. Lumbar spasms present on the left. No trigger points appreciated. Straight leg-raised and FABER's tests were negative bilaterally. The patient is alert and oriented x3. Motor exam was 5/5 throughout. Sensory exam is significant for decreased sensation at the ankles distally at levels L4 through S1. Deep tendon were unable to be elicited in the S1 distribution bilaterally, The patient's gait was

significant for a left-sided limp. Plan: Schedule Norco 10/325 mg 1 tablet BID PRN, Lyrica 300mg BID, Patient is not interested in injections or spinal cord stimulator or intrathecal pump at this time. We will revisit in the future, consider physical therapy, and return to clinic in one month for follow up.

04/05/13: CT Spine Lumbar WO Contrast: Impression: Mild multilevel degenerate disk disease with posterior annular bulging more significant at L4-L5 level. Resulting in mild central canal stenosis. No significant neural foramen narrowing is identified. Findings suggestion of congenital normal variance of central canal stenosis, No CT evidence of large disc protrusion or extrusion, No significant neural foramen narrowing. Incidental note of probably right adrenal adenoma and left adrenal hyperplasia

01/29/15: Office Visit: Follow up with . The patient complained of moderate lumbar pain with numbness and tingling in the lower extremities bilaterally. She was taking Lyrica, Norco and Trazodone. Assessment was nerve root irritation, post laminectomy syndrome and opiate dependency. Medications were refilled

02/24/15: Office Visit: Follow up. The patient complained of moderate low back pain with left sided numbness and tingling. She was taking Lyrica, Trazadone, and Norco. Exam revealed positive VRI. Antalgic gait. Assessment was nerve root irritation, post laminectomy syndrome, and opiate dependency. Medications were refilled.

03/24/15: Office Visit: Follow up. The patient complained of moderate lumbar pain with numbness and tingling in the lower extremities bilaterally. She was taking Lyrica, Norco, and Trazodone. Exam revealed an antalgic gait. Positive for some left lumbar spasms. Assessment was lumbar nerve root irritation and post laminectomy syndrome as well as opiate dependency. recommended 3 lumbar caudal ESI's.

03/30/15: UR: Recommendation and Clinical Rationale: NON-CERTIFY caudal ESI. There is lack of objective radiculopathy (with only vague sensory deficits, "L4-5" and negative neural tension signs in the straight leg raise) and with most significant findings on the most recent imaging studies in 2013 at L3-4 level, one level about the fusions, and 3 levels about the level the proposed injection-caudal- therefore less chance of extravasation of the injectant and benefit at that level. Furthermore given lack of information with respect to compliance and consistency of continued conservative care with a home exercise program, this shot gun approach to an injection in situ without adjunctive functional restoration is of questionable potential benefit, and therefore not medically necessary.

03/31/15: Appeal by the office: Document states, "We are appealing the denial on the injections that were being requested by our doctor. Please go over all information. This is an ongoing issue for the patient and he needs the injections"

04/21/15: Office Visit: Follow up with . The patient complained of moderate lumbar pain with numbness and tingling in the lower extremities bilaterally.

Positions that aggravate pain: standing, bending, walking. Rates pain 6/10. Patient is taking Norco, Lyrica and Trazadone. A&O x 4. Diagnosis: Nerve root irritation, Post-laminectomy Syndrome, Opiate dependency. Plan: Refill medications, Procedure post approval, PT planned.

04/29/15: UR: The request for a lumbar caudal ESI is not certified, as the ODG criteria has not been met. The records provided do not document definitive signs of radiculopathy such as weak reflexes, atrophy, decreased motor strength of positive SLR. There was no imaging studies provided that reveal nerve compression and corroborate with the complaints of radiculopathy. The records do not document what conservative measures have been attempted such as physical therapy and the outcomes of conservative treatment. Based on the above rationale, the request is not certified.

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

This request for a lumbar caudal ESI is not certified based on ODG criteria. There is insufficient documentation of radiculopathy such as weak reflexes, atrophy, decreased motor strength of positive SLR. Additionally, there are no imaging studies which corroborate radiculopathy. The records do not document what conservative measures have been attempted such as physical therapy and the outcomes of conservative treatment. Therefore, this request for Caudal Epidural Steroid Injection is non-certified.

**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, muscle relaxants & neuropathic drugs).
- (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)