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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Epidural steroid injection (ESI) lumbar L4-L5

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)

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 male who sustained an injury injured on XX/XX/XX, when he slipped-and-fell from a ladder and injured his multiple body parts.

On XX/XX/XX, a magnetic resonance imaging (MRI) of the lumbar spine was obtained for lumbar pain. This revealed degenerative disc disease and spondylosis from L1-L2 through L5-S1 and facet arthropathy throughout the lumbar spine. The MRI of the cervical spine was also obtained for cervical degenerative disc disease and pain. This revealed status post anterior cervical fusion from C6-C7; facet arthropathy throughout the cervical spine; mild central canal stenosis in the upper cervical spine due to a small cyst, central disc protrusions; suggestion of a kink in the cervical cord at C3-C4. However no definite extradural defects were seen impinging on the cord.

On XX/XX/XX, XX evaluated the patient for hardware removal. The patient presented with back pain and posterior thigh and calf pain on the left, radiating down to the foot as well as numbness on the entire front of the left leg. He was on hydrocodone and gabapentin. He reported having been

denied injections that were recommended by other providers. Surgical history was significant for L3-L4 fusion on XX/XX/XX, and cervical surgery at C6-C7 in XXXX. Medical history was significant for high blood pressure, kidney stones, anxiety, depression and sexual difficulty. He was unable to work due to his back/neck problems. He admitted to a weight gain of more than 10 pounds. Examination revealed well-healed incisions overlying the lumbar area, nontender to palpation. Lumbar spinous processes at L5-L6 and L6-S1 were tender to palpation. Straight leg raise (SLR) on the left side revealed about 20 degrees from full extension there was pain at the left posterior thigh/buttock. X-rays of the lumbar spine revealed mild joint space narrowing in the hips bilaterally and disc space narrowing and degeneration at L5-L6 and L6-S1 with bridging at L6, also an osteophyte at L3 anteriorly and a fusion bone mass at L5-L6. XX assessed spondylolisthesis, displacement of lumbar intervertebral disc without myelopathy, low back pain and hypertension. An MRI of the lumbar spine was ordered. Abilify and Trazodone were prescribed.

On XX/XX/XX, an MRI of the lumbar spine was completed and showed the patient was status post decompressive surgery with posterior fusion of L3 and L4; degenerative changes at L4-L5 resulting in moderate-to-severe bilateral foraminal and mild spinal canal stenosis; degenerative changes at L2-L3 resulting in moderate-to-severe bilateral foraminal and mild-to-moderate spinal canal stenosis; desiccation of the intervertebral disc, a broad-based disc protrusion and ligamentum flavum hypertrophy at L1 to result in mild-to-moderate bilateral foraminal and spinal canal stenosis; mild bilateral foraminal stenosis at L3-L4 and L5-S1.

On XX/XX/XX, the patient was evaluated for follow-up. Based on the MRI, XX assessed that the most likely to be irritated would be the L5 nerve root in the lateral recess at the L4-L5 level. He recommended an epidural steroid injection (ESI) at the L4-L5 level. XX did not feel the need for surgery.

On XX/XX/XX the patient underwent lumbar ESI at the left L4-L5 level with intraspinal myelography without dural puncture. Diagnosis was lumbar spinal stenosis.

On XX/XX/XX, XX evaluated the patient who stated the pain was actually worse after the injection. He did not get any relief from the injection. He was on Neurontin. A selective nerve root block to the left at L5-S1 was recommended. If he did not get any relief from it, plan was to consider a CT scan to evaluate the fusion at L3-L4. Additional diagnoses of lumbar spinal stenosis, degenerative joint disease of the back and lumbar back pain with radiculopathy were established. Bilateral facet joint injections at L4-L5 and L5-S1 were ordered.

On XX/XX/XX, the patient underwent bilateral lumbar facet joint steroid injections. Diagnosis was lumbar spinal stenosis and lumbar spondylosis without myelopathy.

On XX/XX/XX, XX evaluated the patient post lumbar facet injections. The patient stated he got 50% relief with the injection. Plan was for rhizotomy in the future as the patient was very happy with the results.

On XX/XX/XX the patient underwent a lumbar ESI.

On XX/XX/XX XX completed a peer review analysis and opined if the patient continued to take gabapentin and hydrocodone, he would require a follow-up visit with a prescribing physician every 12 weeks. He also opined the treatment including the provision of oral medications continued to be related to the compensable injury of XX/XX/XX, and that both gabapentin and hydrocodone could be prescribed as generic medications and were reasonable and medically necessary and did not require a weaning process.

On XX/XX/XX, XX evaluated the patient who was doing well on his medications. He had had an episode of "passing out" and fell but did not see a doctor. XX advised him to see his primary care physician (PCP). Examination was within normal limits. XX assessed postlaminectomy syndrome in the lumbar region and lumbar spondylosis without myelopathy. Prescriptions were written for Etodolac ER, tramadol and gabapentin.

On XX/XX/XX, an MRI of the lumbar spine was completed. The study revealed postoperative changes at L3-L4 without complication; L4-L5 with central canal stenosis to 6 mm secondary to a 5-mm generalized disc protrusion with moderate degenerative bilateral foraminal narrowing; L2-L3 with central canal stenosis to 7 mm with mild degenerative bilateral foraminal narrowing; L1-L2 with a 2-mm generalized disc bulge with central canal narrowing to 8 mm and mild degenerative bilateral foraminal narrowing.

On XX/XX/XX, XX evaluated the patient and reviewed MRI results. XX documented she was unable to give anything heavier than tramadol as the patient had faltered a few times on his urine drug screens (UDS). Examination revealed tenderness to the left buttock status post fall when he had passed out. Medications were refilled. The patient was instructed on passive ROM exercises for back strengthening. He was referred to Orthopedic Spine Surgery.

On XX/XX/XX, the patient was evaluated for worsening back pain radiating towards the left hip. MRI results were reviewed. Recommendation was for an ESI at the L4-L5 level on the left and see if he responded. If he did, continuation of the injections and if he did not, then stabilization of the L4-L5 disc space with lateral or posterior lumbar interbody fusion or an ALIF approach. X-rays and MRI of the lumbar spine were ordered.

Per Peer Review Report dated XX/XX/XX, XX denied *the request for a Lumbar Epidural Steroid Injection at Left L4-L5 with Fluoroscopy was not medically necessary. Rationale: "The claimant is noted with complaints of low back pain with radiation to the hip. However, recent examination findings indicating radiculopathy have not been provided. Furthermore, evidence of pain relief of at least 50-70% pain relief for at least 6-8 weeks with the previous ESIs has not been provided. Therefore, this request is not indicated as medically necessary and reasonable at this time."*

On XX/XX/XX, XX appealed for reconsideration of the denied lumbar L4-L5, ESI.

On XX/XX/XX, a reconsideration appeal was denied. Rationale: *“Lumbar Epidural Steroid Injection @ Left Lumbar 4/5 with Fluoroscopy is not medically necessary. Rationale: “The claimant has had prior ESI without relief. There are no exam findings consistent with radiculopathy. There is back and leg pain. There was no indication of the amount and duration of improvement with the prior ESI. The evidence based guidelines do not support repeat injection when the first injection did not provide 6 weeks of significant benefit. Therefore, Lumbar Epidural Steroid Injection @ Left Lumbar 4/5 with Fluoroscopy is not medically necessary.”*

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

The criteria, according to the ODG, for the use of epidural steroid injections are as follows:

- 1) Radiculopathy must be documented by physical examination and 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) for guidance.
- 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.

The request for a Lumbar Epidural Steroid Injection at Left L4-L5 with Fluoroscopy was not medically necessary due to the following rationale:

- The ODG, in the therapeutic phase, identifies documentation of at least 50-70% pain relief for six to eight weeks from previous ESI's, with a general recommendation of no more than four blocks per region per year, as well as decreased need for pain medications, and functional response as criteria necessary to support the medical necessity of additional epidural steroid injections. There is lack of documentation of at least 50-70% improvement following previous injection.

- No clear clinical signs of radiculopathy. For instance, there is lack of documentation indicating the injured worker had radiating pain with the straight leg raise or a positive electrodiagnostic study.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES