

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Rd Irving, TX 75038
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IRO Cert#5301

DATE OF REVIEW: MARCH 14, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Caudal ESI Injection with sedation (62311)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury on XX/XX/XX, when she lifted a box of binders and felt a "pull" in her low back. She was diagnosed with radiculopathy in the lumbar region. She is noted as having had seven previous lumbar surgeries, two of which included hardware. An MRI of the lumbar spine was performed on XX/XX/XX, suggesting an L5-S1 minimal postoperative fibrosis, but there was no frank herniation or compression noted.

Evaluations were most recently provided from XX/XX/XX. The physical examination documented tenderness on examination, bilaterally, at the L5-S1 facet level. Positive straight leg raise testing was reported, bilaterally. Decreased sensation was noted, bilaterally, in the L5-S1 distribution. Patellar tendon deep tendon reflexes were documented at 1+/4, bilaterally.

The official MRI report from XX/XX/XX, reported:

Extensive postoperative changes from prior laminectomies at L4-L5 and L5-S1 with a metallic fusion at L4-L5, Grade I spondylolisthesis at L4-L5, and accentuated lumbar lordosis of the inferior lumbar spine,

Clumping of nerve roots was noted substantially from about L3 and was highly suspected for arachnoiditis,

At T11-T12, there were degenerative disc changes noted, with a mild disc bulge and no frank neural encroachment,

At L1-L2, facet arthropathy was noted,

At L2-L3, slight disc bulges were noted,

At L3-L4, there was moderate facet arthropathy,

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At L4-L5, degenerative disc changes with Grade I spondylolisthesis, a prior metallic fusion, a prior laminectomy, and a slight foraminal narrowing were noted fairly rightward. Minimal postoperative enhancing fibrosis was noted,

At L5-S1, there was minimal fibrosis with scant fluid collection that was more prominent rightward, representing a possible seroma, although nonspecific. No frank herniation or compressive disc disease was seen, with slight foraminal narrowing inferiorly, and

A small focal T2 hyperintensity superior aspect of the right kidney that was likely a small cyst. Clinical correlation was recommended.

The patient's maintenance medications as of XX/XX/XX, included Neurontin and Trazadone. The Percocet was discontinued, due to noncompliance, and she was noted to have failed when using Elavil. The past medical history included hypothyroidism and obesity.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

As noted in the nationally publicized Official Disability Guidelines, the medical necessity for the proposed caudal epidural steroid injection (ESI) with sedation would not be supported. The records provided support that the patient had extensive prior lumbar surgeries. The most recent MRI suggested minimal postoperative fibrosis at L5-S1 with no frank disc herniation or compressive disease. The physical examination findings noted most recently, on XX/XX/XX, did not note any clear evidence of a radiculopathy, such as a loss of reflex or myotomal

weakness to support a clinical radiculopathy. Changes in the physical examination findings suggesting an acute process have not been documented. Electrodiagnostic testing was not performed. The records indicated that the patient had prior inconsistencies with urine toxicology screens, resulting in the discontinuation of her oral opioid medications. Without any clinical corroboration of a radiculopathy on the diagnostic imaging, therefore the request for a caudal ESI is not medically warranted.

ODG ESIs

Note: The purpose of an ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, a reduction of medication use, and the avoidance of surgery; however, this treatment alone offers no significant or long-term functional benefit.

Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination must be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.

Must be initially unresponsive to conservative treatment (exercises, physical methods, nonsteroidal anti-inflammatory drugs [NSAIDs], muscle relaxants, and neuropathic drugs). Injections should be performed using fluoroscopy (live X-ray) and injection of contrast for guidance.

In the diagnostic phase, at the time of the initial use of an ESI (formally referred to as the "Diagnostic Phase" the 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 (less than 30% is a standard placebo response). A second block would also not be indicated if the first block is accurately placed unless:

There was a question of the pain generator,

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There was the possibility of inaccurate placement, or

There was 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.

No more than two nerve root levels should be injected using transforaminal blocks.

No more than one interlaminar level should be injected at one session.

In the therapeutic phase, after the initial block/blocks are given, (see "Diagnostic Phase" above) and found to produce pain relief of at least 50% to 70% pain relief for at least six to eight weeks, additional blocks may be supported. This is

generally referred to as the "Therapeutic Phase." Indications for repeat blocks include an acute exacerbation of pain or a

new onset of radicular symptoms. The general consensus recommendation is for no more than four blocks, per region, per year. (CMS, 2004) (Boswell, 2007)

Repeat injections should be based on continued objective documented pain relief, the decreased need for pain

medications, and the functional response.

Current research does not support the routine use of a "series-of-three" injections in either the Diagnostic Phase or the Therapeutic Phase. We recommend no more than two ESIs for the initial phase and rarely more than two for therapeutic treatment.

It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks, sacroiliac blocks, lumbar sympathetic blocks, or trigger point injections. This may lead to an improper diagnosis or unnecessary treatment.

Cervical and lumbar ESIs 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 would not be worth the risk for a treatment that had no long-term benefit.)

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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES