

Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

DATE: February 1, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5-S1 Lumbar Caudal Epidural Steroid Injection 62311 77225.26

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

The reviewer is certified by the American Board of Orthopedic Surgery with over 42 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]:

The claimant is a male who injured his low back when unloading a panel while working on XX/XX/XX.

XX/XX/XX through XX/XX/XX: The claimant underwent physical therapy XX. An evaluation by XX, PT on XX/XX/XX noted that impairments remaining were pain, decreased L-sp mobility, strength, flexibility, altered posture and body mechanics. Outcome Measures: MLBPDQ: 14 = 28% disability. Daily note dated XX/XX/XX: Patient continues to present with decreased core strength, decreased postural awareness/control and lumbar spine mobility. These deficits prevent him from safely lifting panels into machine at work.

XX/XX/XX: MRI Lumbar WO Contrast report. IMPRESSION: Mild broad-based posterior disc bulge is seen at L2-L3 and L5-S1. No central canal stenosis is seen. Bilateral foraminal narrowing is seen at L5-S1, worse on the right.

XX/XX/XX: The claimant was evaluated for low back pain, worse at night. Walking, standing, sitting, and prolonged physical activity increased the pain. It was noted that he had conservative treatment in the past, but he continued to experience pain. He stated that physical therapy made his pain worse. His medications included cyclobenzaprine, etodolac, paroxetine, Ultracet 37.5/325 mg, Zanaflex 4 mg, Celebrex 200 mg, and methylprednisolone 4 mg. His smoking status was remarkable for being a current every day smoker. On exam, he had good range of motion in all extremities. DTRs were equal and symmetric and 2/4. No long tract signs were seen. Negative Romberg's sign. Negative Hoffmann's sign. Negative Babinski. Negative reverse radial reflex. Normal gait pattern. Upper and lower extremity strength 5/5. There was significant spinal tenderness in the paraspinal muscles. Bilateral SLR negative. No Waddell's sign present. Normal sensation in all extremities. Normal strength. Negative Spurling's and negative Lhermitte's. Good range of motion with flexion/extension, side bending, and rotation. Spinal motion was with pain. X-rays performed in office demonstrated no instability and some disc space narrowing seen at L5-S1. MRI was reviewed demonstrating severe neuroforaminal stenosis at L5-S1 on the right side. ASSESSMENT: Low back pain with

some radiculopathy secondary to lumbar disc disease at L5-S1 with severe neuroforaminal stenosis, right side. PLAN: Recommend lumbar epidural steroid injection. He was given a prescription for a Medrol Dosepak, Celebrex, cephalexin, and Ultracet.

XX/XX/XX: UR. RATIONALE: The submitted documentation does not show that the patient is suffering from any type of radiculopathy. There is no radiating pain. The patient’s motor exam, reflexes, and sensory exam were normal. Given that the patient is not suffering from any type of subjective or objective radiculopathy, the requested L5-S1 lumbar caudal epidural steroid injection 62311 77225.26 is not medically necessary and is non-certified.

XX/XX/XX: UR by. RATIONALE: The documentation provided did not contain evidence of objective exam findings suggestive of radiculopathy.

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

The previous adverse decisions are upheld. Based on the submitted history and physical examination, there is no evidence of radiculopathy. The indications as cited by the ODG criteria for epidural steroid injections in the lumbar spine are not met. Therefore, the request for L5-S1 Lumbar Caudal Epidural Steroid Injection 62311 77225.26 is not medically necessary.

ODG:

<p>Epidural steroid injections (ESIs), therapeutic</p>	<p>Criteria for the use of Epidural steroid injections: <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> <ol style="list-style-type: none"> (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) <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. (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) <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) (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
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	<p>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)