

Vanguard MedReview, Inc.

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient caudal epidural steroid injection under fluoroscopy

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

This case was reviewed by a Board Certified Doctor of Anesthesiology with over 6 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 sustained a low back injury in XXXX. He has had multiple procedures performed including an L5-S1 fusion with instrumentation in XXXX, a spinal cord stimulator implantation, physical therapy, epidural steroid injections and a chronic pain management program.

XX/XX/XX: Office Visit. **Subjective:** The patient complains of low back pain that radiates into both extremities. Pain level is 7-9/10. Constant pressure, tightness, weakness and pain on his back and both legs. Stimulator is not effective. He wants the pump. His function is very poor. **Objective:** No significant changes in the physical exam since the last office visit. **Assessment:** Pain Chronic Postoperative, Lumbar Radiculitis, Lumbar Radiculopathy, Lumbar Herniated Nucleus Pulposus, Lumbar Post Laminectomy Syndrome, Sacrolitis, Pain Chronic Syndrome **Plan:** Ultram-ER 200 mg I po q d#30 rf x0, Ultram 50mg I pot id #90 rf x0 Follow up in one month.

XX/XX/XX: Office Visit. XX is seen today because he needs a referral to see XX. He was previously a patient of XX. He had a spinal cord stimulator but he stopped using it because it did not help. A pain pump was then recommended. He was not interested in that then, but he would like to reconsider. Examination shows multiple incisions over his back. ROM is limited in all directions. He has back pain with straight leg raising. I do not detect any decrease motor weakness in the _____, quadriceps, tibialis anterior, exterior _____ longue, gastrocnemius, or _____ group. I gave him the referral.

XX/XX/XX: Office Visit. **HPI:** The patient complains of low back pain that radiates into both lower extremities. Able to sit, walk and stand for more than 30 minutes. Pain level now 4-6/10. Worst 7-9/10, best 4-6/10. Pain feels like aching and pressure and is relieved by lying down. The patient is on disability now. Negative for significant weight

gain/loss. Numbness weakness tingling not noted. **Objective:** No significant changes in the physical exam since the last office visit. Normocephalic, atraumatic. Lumbar: Toe walking; poor. Heel walking; poor. Deep tendon reflexes: diminished in the lower extremities. Straight leg raise positive bilaterally. Positive Patrick's sign bilaterally. No pain of the sacroiliac joint bilaterally. Pain in the lumbar facets bilaterally. **Assessment:** Pain chronic post-operative, lumbar radiculitis, lumbar radiculopathy, lumbar herniated nucleus pulposus, lumbar post laminectomy syndrome, sacroiliitis, pain chronic syndrome. **Plan:** psych evaluation, check stimulator battery, caudal ESI, Follow up in two weeks.

XX/XX/XX: UR. **Rationale for Denial:** Claimant sustained an industrial low back injury in XXXX. He is status post 360° lumbar fusion in about XXXX. Spinal cord stimulator implantation was also authorized. Other treatment has included physical therapy, ESI's and other injections, and a chronic pain management program completed XXXX. No recent ESI's are documented. XX/XX/XX a request for repeat caudal ESI was denied following peer review, noting insufficient documented objective evidence for radiculopathy per physical exam, and insufficient documentation of response to previous ESI's XX/XX/XX lumbar CT scan showed solid fusion L5-S1, with some facet Arthropathy and disc bulging at L3-4, L4-5. XXXX office note stated that claimant had stopped using spinal cord stimulator because it did not help. On exam, lumbar ROM was limited and straight leg raising test produced back pain. There was no discrete motor weakness in the lower extremities. XX/XX/XX office note documented complaints of low back pain radiating to both lower extremities. There was no numbness, tingling, or weakness in the extremities. On exam, straight leg raising test was positive bilaterally. Deep tendon reflexes were diminished in the lower extremities. Outpatient caudal ESI under fluoroscopy. There is insufficient documented objective evidence of radiculopathy and insufficient documentation of results of previous ESIs to meet ODG criteria for repeat injection.

XX/XX/XX: UR. **Rationale for Denial:** There was a request submitted XX/XX/XX for a caudal epidural steroid injection which was denied. office visit noted low back pain with radiation to both lower extremities. He noted that toe and heel walk were poor and a caudal epidural steroid injection was requested. office visit note on noted that the spinal cord stimulator was not helpful and there was no motor weakness. There was an office visit on XX/XX/XX, and an appeal on XX/XX/XX that offered no additional information. ODG requires evidence of radiculopathy in corroboration with MRI finding to authorize a caudal epidural steroid injection.

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

There was a request submitted dated XX/XX/XX for a caudal epidural steroid injection which was denied. Office note from visit on XX/XX/XX noted low back pain with radiation to both lower extremities. He noted that toe and heel walk were poor and a caudal epidural steroid injection was requested. office visit note noted that the spinal cord stimulator was not helpful and there was no motor weakness. Office visit on XX/XX/XX, and an appeal on XX/XX/XX that offered no additional information. ODG requires evidence of radiculopathy in corroboration with MRI finding to authorize a caudal epidural steroid injection. Therefore, this request for caudal ESI is non-certified.

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)