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DATE NOTICE SENT TO ALL PARTIES: 6/11/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a lumbar caudal epidural steroid injection with imaging guidance.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Anesthesia & Pain Management. The reviewer has been practicing for greater than 10 years.

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)
The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a lumbar caudal epidural steroid injection with imaging guidance.

PATIENT CLINICAL HISTORY [SUMMARY]:
Claimant has a filed a claim for lower back pain associated with an industrial injury of XXXX. On XXXX, claimant reported ongoing issues with chronic low back pain, 4/10, with attendant difficulty performing physical activity and sitting tasks. The claimant had undergone prior lumbar discectomy surgery through another practitioner, the attending provider noted. The claimant also had superimposed issues with anxiety and depression. Medications include XX, XX, XX, XX, XX and XX. Well-preserved, 5/5 lower extremity motor function and a normal gait were present. XX and XX were renewed. A full record of what treatments had transpired to date was not provided. Claimant was described as having persistent lower extremity paresthesias. On XXXX, claimant reported ongoing issues with chronic low back pain radiating into lower extremities, 5/10. Epidural steroid injection was proposed while XX, XX and XX were also ordered. The claimant was advised to pursue psychological testing.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
Epidural steroid injections, diagnostic are recommended as indicated below.

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 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 and muscle relaxants).
3. Infections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
4. Diagnostic Phase: At the time of the initial use of an ESI (formally referred to 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.
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 on 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 percent 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.
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 "series of three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.
10. It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
11. Cervical and lumbar steroid injection should not be performed on the same day;
12. Additional criteria based on evidence of risk:
a. ESIs are not recommended higher than the C6-C7 level;
b. Cervical interlaminar ESI is not recommended; &
c. Particulate steroids should not be used.

Per evidence-based guidelines, and the records submitted, this request is non-certified. Per ODG, epidural steroid injections are recommended if there's evidence of radiculopathy that is corroborated by imaging findings. Claimant has no overt radicular findings on exam to support this request. Additionally, the MRI does not show any evidence of herniated nucleus pulposus, protrusion or root impingement. There needs to be evidence that the patient has completed conservative treatment. Documentation provided for review does not demonstrate failure of conservative therapy, nor is there documentation to clearly delineate which treatments have been performed to date and what the patient's reaction to those treatments has been. Therefore, this request is found to be not medically necessary at this time.

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)**