Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Date notice sent to all parties: 05/21/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Caudal epidural steroid injection (ESI)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Orthopedic Surgery - Fellowship Trained in Spinal Surgery

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

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Caudal ESI – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX examined the patient on XXXX for XXXX low back and right shoulder. A lumbar MRI dated XXXX was reviewed and there was a hearing scheduled regarding extent of injury. XXXX was not very active due to not wanting to increase XXXX back pain. XXXX was XXXX inches tall and weighed XXXX pounds. XXXX had a shuffling gait and severe restriction in right shoulder ROM, as well as the back. XXXX was referred to an orthopedic surgeon and an EMG/NCV study was ordered. It was felt the MRI showed moderately severe foraminal narrowing with possible impingement to the L3 nerve root. XXXX examined the patient on XXXX who felt XXXX was an excellent candidate for a lumbar ESI. XXXX examined the patient on XXXX for XXXX right shoulder post-surgery. A right subacromial space injection was done at that time and continued therapy was recommended. On XXXX, XXXX recommended continued therapy for the shoulder. XXXX also recommended it be continued on XXXX. XXXX examined the patient on XXXX for neck pain, right shoulder pain, and low back pain. XXXX was on XX/XX, XX, and XX. XXXX noted XX made XXXX constipated and XXXX had done therapy without improvement. XXXX used a cane and had an antalgic gait on examination. XXXX had no spasms or trigger points and had bilateral facet tenderness at L3-S1. Strength was 3-4/5 in the right lower extremity and 4/5 in the left. DTRs were 0-1 throughout. XXXX noted XXXX had an injection the year before which did not help. XX, XX, and XX were prescribed. Since XXXX had failed 12 sessions of therapy and XX, an ESI was recommended. On XXXX, XXXX recommended a right shoulder MRI arthrogram. On XXXX, XXXX requested a caudal ESI. On

XXXX, XXXX, on behalf of XXXX, provided a denial for the requested caudal ESI. On XXXX, XXXX provided a letter noting the caudal ESI was reasonable and was consistent with the Official Disability Guidelines (ODG). On XXXX, XXXX, also on behalf of XXXX, provided another denial for the requested caudal ESI.

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

Based on the documentation, it was noted the patient has failed to improve with prior ESI therapy. The patient suffers from essentially axial pain and does not have objective evidence of radiculopathy. At this time, the patient does not meet the criteria for an ESI per the ODG. The ODG indicates repeat ESIs should be based on continued objective documented pain and functional improvement of at least 50%. An ESI is indicated as an adjunct to other successful treatments to improve functional status in a patient with radiculopathy. This patient has failed this same type of treatment in the past. Therefore, the requested caudal ESI is neither medically necessary nor appropriate nor is it in accordance with the recommendations of the ODG. The previous adverse determinations should be upheld 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**
- **X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- **X 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)**