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Notice of Independent Review Decision

DATE OF REVIEW: 03/24/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Reconsideration of Forte's NON-AUTHORIZATION of outpatient caudal lumbar epidural steroid injection (ESI). Original decision UPHELD. Recommendation NON-AUTHORIZATION

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

Texas Board Certified Physical Medicine & Rehabilitation
Texas Board Certified Pain Management

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 06/29/10 - MRI Lumbar Spine
2. 07/27/10 - Lumbar Myelogram
3. 07/27/10 - Post-Myelogram CT Lumbar Spine
4. 01/05/11 - Clinical Note - Unspecified Provider
5. 01/05/11 - Clinical Note - MD
6. 01/18/11 - Electrodiagnostic Studies
7. 01/13/11 - Clinical Note - DO
8. 01/24/11 - Clinical Note - DO
9. 01/25/11 - MRI Lumbar Spine
10. 02/02/11 - Notice of Utilization Review Findings
11. 02/03/11 - Clinical Note - DO
12. 02/21/11 - Clinical Note - DO
13. 03/01/11 - Notice of Intent to Issue an Adverse Determination

14. 03/02/11 - Notice of Utilization Review Findings
15. 03/07/11 - Pre-Authorization Form
16. 03/14/11 - Notice of Intent to Issue an Adverse Determination
17. 03/15/11 - Notice of Utilization Review Findings
18. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female with a history of back pain.

An MRI of the lumbar spine performed 06/29/10 demonstrated a posterior broad-based disc bulge at L1-L2. There was mild bilateral facet hypertrophy. The thecal sac remained ample. There was no significant foraminal narrowing. At L2-L3, there was bilateral facet hypertrophy. There was thickening of the ligamentum flavum. There was a posterior broad-based disc bulge. The thecal sac measured 11 mm. There was no significant foraminal narrowing. At L3-L4, there was bilateral facet hypertrophy. There was thickening of the ligamentum flavum, right greater than left. There was a posterior broad-based disc bulge. The thecal sac measured 12 mm in the midline. There was no significant foraminal narrowing. At L4-L5, there was marked bilateral facet hypertrophy. There was a posterior broad-based disc bulge. There was thickening of the ligamentum flavum. The thecal sac measured 10 mm, but was somewhat narrowed laterally. There was bilateral lateral recess narrowing. There was mild bilateral foraminal narrowing. Disc material contacted the exiting bilateral L4 nerve roots. Assessment at this level was somewhat limited by susceptibility artifact from metallic hardware. At L5-S1, the assessment was somewhat limited by susceptibility artifacts. L5 laminectomies were noted. There was enhancing granulation tissues within the central canal, compatible with epidural fibrosis. There was residual posterior broad-based disc bulge. Disc material appeared to contact the exiting L5 nerve roots bilaterally. There was granulation tissue surrounding the descending S1 nerve roots within the canal. The thecal sac was reduced to 4 mm. There was some increased epidural fat anteriorly which contributed to canal stenosis at that level. There was a small amount of non-enhancing fluid within the postoperative bed in the midline of the back. Additionally, there was susceptibility artifact within the soft tissues of the back at approximately the L2-L3, likely a surgical suture.

A lumbar myelogram performed 07/27/10 demonstrated pedicle screws at L5 and S1 with bone graft plug in the L5-S1 disc space and slight anterolisthesis of L5 upon S1. The left S1 root sleeve filled less well than the right. There was lumbar levoscoliosis noted. Post-myelogram CT of the lumbar spine performed 07/27/10 demonstrated a Schmorl's node at T12-L1 in the inferior endplate of T12. There was no herniation or spinal or foraminal stenosis. There was degenerative anterior spondylosis. At L1-L2, there was no appreciable herniation or spinal or foraminal stenosis. The perineural fat planes were normal. There was some mild facet osteoarthropathy. There was facet subluxation on the right. At L2-L3, there was pain infusion pump catheters entering at this level, which ascended in a cephalad direction. There was no herniation or spinal or foraminal stenosis. There was some loss of the foraminal fat planes on the right at L2-L3, associated with annular disc bulge. At L3-L4, there was annular bulging with inferior

encroachment of the exit foramina bilaterally, right greater than left. There was partial effacement of the foraminal fat planes on the right, secondary to inferior foraminal disc bulging. At L4-L5, there was some mild annular disc bulging with no focal herniation. The perineal fat planes were normal. There was degenerative facet osteoarthropathy and joint space narrowing and spurring, with some intrafacetal gas on the right. At L5-S1, there was disc material and a metallic marker at the L5-S1 disc space. There were bilateral pedicle screws at L5 and S1 bridged by interconnecting rods and slight anterolisthesis of L5 on S1. There was remodeling of the inferior endplate of L5 and superior endplate of S1 at the disc space level. There was bilateral spondylolysis at L5 and a previous posterior laminectomy at this level. The exiting root sleeves filled poorly. There was slight anterior listhesis of L5 upon S1. There was postoperative perithecal granulation tissue. There was a “C” shaped levoscoliosis.

The employee was seen for evaluation on 01/05/11. The note stated the employee was diagnosed with lung cancer. The note stated the employee was still under care and had not been released. The employee complained of pain of the back and lower extremities. The employee stated she slipped and fell in xx/xx . The employee reported weakness and numbness involving the legs and feet. Physical examination revealed no evidence of swelling, masses, or spasms of the thoracolumbar spine. There was no discomfort over the sacroiliac joints. Motor strength of the left dorsiflexor was 3-/5. There was decreased sensation on the left involving the medial and lateral calf, and markedly to the dorsum and lateral aspect of the foot. Straight leg raise was negative. There was no sustained clonus noted. Radiographs of the lumbar spine demonstrated retained hardware at L5-S1. There was an interbody cage in place, and this appears to be unchanged. There was a scoliotic curve in the lumbar spine. The employee was assessed with arthrodesis status, foot pain, peripheral neuropathy, and lumbar radiculopathy. The employee was recommended for electrodiagnostic studies and MRI of the lumbar spine.

Electrodiagnostic studies performed 01/18/11 demonstrated evidence of moderate L5 and S1 radiculopathy bilaterally. There was persistent evidence of a moderate peripheral neuropathy of the bilateral lower extremities affecting the sensory and motor components of the nerves.

The employee saw Dr. on 01/24/11. Physical examination revealed moderate lumbar interspinous tenderness. Straight leg raise was to 60 degrees on the right. The note stated lumbar radiculopathy was exacerbating her reflex sympathetic dystrophy pain complaints associated with her work injuries. The employee was recommended for caudal epidural block.

An MRI of the lumbar spine performed 01/25/11 demonstrated a small bulge at L1-L2 with mild narrowing of the right subarticular recess. There was no canal or significant foraminal stenosis. At L2-L3, there was a disc bulge, ligamentum flavum prominence, and facet arthropathy without canal stenosis. A superimposed right foraminal protrusion resulted in mild right foraminal stenosis. At L3-L4, there was a disc osteophyte

complex, ligamentum flavum prominence, and facet arthropathy with mild flattening of the thecal sac. There was no overt canal stenosis. There was mild foraminal narrowing. At L4-L5, there was a disc bulge, ligamentum flavum prominence and facet arthropathy with moderate stenosis of the thecal sac, moderate right foraminal stenosis, and severe left foraminal stenosis. There was a right central inferiorly extending disc extrusion extending inferiorly to the level of the L5 lateral recess with encroachment upon the descending right L5 nerve root sleeve. At L5-S1, there was Grade II anterolisthesis. There was uncovering of superior disc margin and question of prior L5 pars defects. The level demonstrated laminectomy. There was apparent early termination of the thecal sac. At the inferior L5-S1 disc margin, anteroposterior dimension of the spinal canal was reduced to 4-5 mm. There was severe left and moderate right foraminal stenosis with encroachment upon the exiting L5 nerve root sleeves.

The employee saw Dr. on 02/21/11 with complaints of pain in the neck, arm, and leg associated with complex regional pain syndrome. Physical examination was not performed. The employee's pain pump was refilled.

The request of outpatient caudal lumbar epidural steroid injection was denied by utilization review on 03/02/11 due to no physical examination that correlated with imaging and electrodiagnostic studies to unequivocally describe a radiculopathy.

The request for outpatient caudal lumbar epidural steroid injection was denied by utilization review on 03/15/11 due to no indication as to why the employee had a peripheral neuropathy. There was no documentation of details about the tumor in the lung, including if this was a cancer or if she required additional treatment. It was important to obtain additional information about the employee's underlying medical condition before all of her symptoms are attributed to either complex regional pain syndrome or to lumbar radiculopathy, particularly as her examination was limited in terms of documentation of a radiculopathy in a dermatomal distribution.

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

The requested outpatient caudal lumbar epidural steroid injection is not recommended as medically necessary. The MRI studies do show significant foraminal stenosis to the left at L4-L5 and L5-S1 with prior surgical changes at L5-S1. Also, the employee does have positive electrodiagnostic studies. This may be due to surgical changes. The employee does not demonstrate any clear focal neurologic deficits on examination, which would be consistent with the MRI and electrodiagnostic study findings. The employee also has no clear radicular pain patterns that are consistent with the diagnostic study findings.

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

Official Disability Studies, Online Version, Low Back Chapter

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) 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.)