

IRO Express Inc.

An Independent Review Organization

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DATE OF REVIEW: JUNE 27, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ASC outpatient lumbar epidural steroid injection times one (#1) at L3-4 (under fluoroscopy)

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

Board certified

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office notes, Dr., 11/18/02, 12/16/02, 12/30/02, 01/23/03, 03/03/03, 03/20/03, 04/07/04, 06/15/03, 06/26/03, 07/17/03, 08/14/03, 09/11/03, 11/03/03, 01/15/04, 04/19/04, 07/19/04, 09/30/04, 01/13/05, 04/14/05, 05/12/05, 07/14/05, 11/10/05, 08/17/06, 03/15/07, 04/12/07 and 05/03/07

Operative report, 03/12/03, 09/09/03, 10/10/03 and 04/04/07

History and physical, 10/10/03

Discharge summary, 10/11/03

Lumbar spine x-rays, 11/03/03, 07/19/04 and 08/17/06

Independent Medical Evaluation, Dr., 09/01/05

Note, 09/01/05

Record review, Dr., 06/10/06

Lumbar spine CT scan, 04/04/07

Review, Medical Director, 04/19/07 and 05/1/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who developed severe low back, bilateral hip and leg pain after falling on some stairs, striking his back and buttocks on xx/xx/xx. His symptoms were much more severe in the right leg with some numbness, dysesthesias and weakness in the right leg despite extensive therapy, Ibuprofen, Neurontin and activity restriction. His history was significant for a skull fracture at age 8 causing seizures, knee pain, depression, knee surgery around xxxx and hypertension. It was also documented that the claimant was a recovering alcoholic. The claimant was diagnosed with lumbosacral strain-contusion syndrome with degenerative disc disease at L4-5 and L5-S1 and right lumbar radiculopathy.

Ultimately on 10/10/03 the claimant underwent a decompressive laminectomy at L4-S1, bilateral L4-S1 root decompression with opening of lateral recesses and foraminotomies, bilateral excision of a herniated disc at L4-5 and L5-S1 with root decompression, bilateral L4-5 and L5-S1 anterior spinal column arthrodesis, bilateral L4-S1 posterolateral fusion, bilateral L4-S1 pedicle screws and rods with L4-5 cross link and a morselized autograft.

X-rays of the lumbar spine performed on 11/03/03 showed postoperative changes secondary to posterior decompression procedure with bilateral posterior fusion at L4-5 and L5-S1, bilateral pedicle screws at L4-S1 transfixing the posterior compression plates extending from L4-S1. Bilateral interdisc spaces were present at L4-5 and L5-S1 and appeared seated within these disc spaces, and a bilateral bony fusion process extending from L4-5. The claimant continued to do well with x-rays showing a progressive fusion with good alignment. On 04/19/04 he was encouraged to be active and begin to look for lighter work.

X-rays of the lumbar spine performed on 07/19/04 demonstrated postoperative change from L4-S1 with posterior rods, pedicle screws, laminectomy defects, autologous bone graft and disc spacers which appeared stable. There was no evidence for hardware complication and alignment was stable.

The claimant presented to Dr. on 05/12/05 stating that he had twisted his back while getting out of bed about 10 days prior but that he was feeling quite a bit better on the date of the visit. There was a little right paralumbar muscle tightness, but fairly good flexibility of the low back.

Dr. performed an Independent Medical Evaluation on 09/01/05. The claimant reported improvement postoperative, but still had low back, but no leg pain. He had tried to return to light duty work, but had worsening symptoms. He was taking Ultram, Hydrocodone and Toprol. A prior functional capacity evaluation performed on 03/24/04 indicated that the claimant was capable of medium to light duty with lifting up to 35 pounds occasionally and 18 pounds frequently. He was given a 25 percent impairment rating on 05/11/04. Examination on 09/01/05 showed 90 degrees of straight leg raise in a sitting position and 80 degrees of straight leg raise on the left in a supine position and 75 degrees on the right which was limited by back pain only. He had decreased pinprick sensation on the dorsal aspect of his right foot and toes in the L5 and S1 distributions. Degenerative disc disease at L4-5 and L5-S1 with surgical fusion was diagnosed. Dr. opined that the claimant's complaints correlated with his objective findings; that no further surgery was indicated, but that further treatment should include aerobic exercise and back exercises at home and a reduction in Hydrocodone. He indicated that

continued chiropractic or other alternative medical treatments were not indicated. Dr. also felt that it was essential that the claimant return to work with restrictions of light to medium duty, no lifting over 25 pounds and no frequent bending or twisting of the back.

Dr. saw the claimant on 12/08/05 and recommended continuation of his current medications and prescribed Hydrocodone, Carisoprodol, Toprol, and Gabapentin. At Dr. visit on 03/09/06 the claimant stated he was moving to Fort Worth. He was walking well and was taking Hydrocodone and Soma. Continued chronic opioid therapy and referral to a pain specialist after moving were recommended.

Dr., orthopedic surgeon reviewed the claimant's records on 06/10/06 and opined that the claimant's current diagnoses were post laminectomy syndrome and chronic pain syndrome; that his current treatment has been reasonable and necessary and probably required prolonged opioid use; that the current diagnoses stemmed from the surgery and thus could be traced back to the xx/xx/xx injury; that he would probably remain very much the way he was now; and that the use of opioid medications at the current level was reasonable, but not at an increased frequency and that Soma was not justifiable.

Lumbar x-rays performed on 08/17/06 revealed postoperative changes at L4-S1 without hardware complications.

The claimant presented again to Dr. on 08/17/06 after a lapse in treatment since 11/05. He was working doing janitorial duties and complained of mild aching low back pain since the last visit that had exacerbated about 2 weeks prior without injury. He had discomfort in the lumbosacral region, mainly on the right side with an aching pain in both legs, mainly on the right. X-rays of the lumbosacral spine showed a solid fusion from L4 to the sacrum with normal alignment. Decreased mobility of the low back with tenderness over the right paralumbosacral region, a little tenderness over the right sciatic outlet, a positive straight leg raise on the right at about 45 degrees, 1 plus reflexes in the ankles and 2 plus in the knees and a slight right antalgic gait were found on examination. Exacerbation of chronic mechanical low back pain was diagnosed and Hydrocodone, Motrin, Flexeril, activity limitation and a lumbar epidural steroid injection were recommended.

Dr. next saw the claimant on 03/15/07 for continued severe low back pain and bilateral aching pain in the hips and legs with paralumbar muscular tightness and decreased mobility of the low back. The lumbar epidural steroid injection was reportedly denied.

A lumbar myelogram was performed on 04/04/07 and showed postoperative changes from L4-S1, mild wasting of the dural sac at L3-4 and a mild anterior extradural defect at L3-4. The post CT showed: L3-4: mild broad-based bulging of the disk causing mild encroachment upon the anterior aspect of the dural sac and inferior recess in the neural foramina, degenerative changes involving the facet joints with facet laxity, thickening of the ligamentum flavum posteriorly with mild spinal canal stenosis and mild bilateral neuroforaminal stenosis; L4-5 and L5-S1: Postoperative change secondary to a posterior decompression procedure, bilateral posterior fusion, bilateral pedicle screws at L4-5 and L5-S1 transfixing the posterior compression plate, bilateral posterior bony fusion processes, bilateral interdisk spacers within the L4-5 and L5-S1 disk space.

At the 04/12/07 visit the claimant reported continued severe mid-lumbar pain with aching pain in the hips and legs. He walked with a flexed posture to the low back and had a loss of lumbar lordosis. Dr. stated that the recent myelogram and CT showed no problems in the area of the previous surgery from L4 to the sacrum with a wide open

canal and no root compression, herniated disc or stenosis, but some central and bilateral defects at L3-4 with some bulging of the disk and some thick ligamentum flavum and moderate lateral recess stenosis. Increased Hydrocodone and a lumbar epidural steroid injection were ordered. A review of the claim on 04/19/07 denied the requested lumbar epidural steroid injection at L3-4 due to the lack of objective findings supportive of radiculopathy and that his complaint was not predominantly of leg pain in a dermatomal distribution with corroborative exam findings for radiculopathy. Dr. appealed the denial. The claim was reviewed again on 05/11/07 and denied.

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

The claimant is a male with a long history of low back pain and degenerative disc disease documented by multiple studies including MRI. The claimant has had previous surgery, which included foraminotomy with root decompressions, excision of herniated discs, and interbody fusion with screws and autograft insertion. More recently, the claimant has had an exacerbation of his low back pain as a result of mechanical forces. The review of the clinical history documents significant elements of radicular low back pain. Although there is some conflicting evidence, the general clinical presentation described by the treating physician matches the known dermatomal distribution for radicular pain at the L3-4 level. In the Reviewer's experience, it is very common for patients such as this case to need intermittent epidural steroid injection due to re-exacerbation of low back radicular pain such as the above. These injections can be both diagnostic and therapeutic. Therefore, the Reviewer's medical assessment is that the requested services are medically necessary.

An Advanced Interdisciplinary Comprehensive Course: Course Directors:, M.D. and, Ph.D.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Radiculopathy must be documented. Objective findings on examination need to be present.

- Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
- Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
- In the therapeutic phase (the phase after the initial block/blocks were given and found to produce pain relief), repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.

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)