

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW: APRIL 24, 2008**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Level 2 lumbar TESI, J codes with MAC anesthesia (64483, 64484, 77003, 01992)

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

The physician providing this review is a Doctor of Medicine (M.D.). The reviewer is national board certified in Physical Medicine and Rehabilitation as well as Pain Medicine. The reviewer is a member of International Spinal Intervention Society and American Medical Association. The reviewer has been in active practice for ten years.

**REVIEW OUTCOME**

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

Overturned (Disagree)

Medical documentation supports the medical necessity of Level 2 lumbar TESI, J codes with MAC anesthesia (64483, 64484, 77003, 01992).

ODG criteria have been used for denials.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a xx-year-old male who slipped and fell against a wall injuring his lower back.

No treatment history is available from the date of injury till June 2006.

In June 2006, magnetic resonance imaging (MRI) of the lumbar spine revealed a broad-based disc bulge and facet hypertrophy at L4-L5, right greater than left, with narrow bilateral lateral recess likely contacting the right L5 nerve root at the lateral recess; central disc protrusion at L5-S1 superimposed on broad-based disc bulge likely contacting the right S1 nerve root at the lateral recess; and a broad-based disc bulge and facet hypertrophy at L3-L4.

In November 2006, a lumbar myelogram/post-myelogram computerized tomography (CT) scan showed a broad-based central/right paracentral diffuse disc bulge at L4-L5 measuring approximately 7 mm with moderate impression on the thecal sac with compression of the exiting right L5 nerve root with mild-to-moderate central spinal stenosis; mild diffuse disc bulge at L3-L4 with mild central canal stenosis; and a 3-4 mm central disc protrusion at L5-S1 abutting and minimally compressing the exiting right S1 nerve root.

DO., performed a peer review and noted the following treatment history: *In January 2004, M.D., diagnosed right S1 radiculopathy, right S1 scar tissue abutment, and entrapment and low back pain. He noted the patient had two transforaminal epidural steroid injections (ESI) and continued to work full time. On November 29, 1995, Dr. performed a right L4-L5 laminotomy and discectomy; and on April 8, 1999, he performed a right L4-L5 redo laminotomy and discectomy. The patient had one work incident in xxxx on an oilrig and another one in xxxx when he had fallen in a cellar. He had one surgery in 1995 and a second one in 1998. In 2004, the patient received three transforaminal ESIs. In March 2005, MRI showed arachnoiditis and scar tissue encasing the L5 nerve root. In 2005, Dr. administered right L5 and S1 transforaminal ESI x3 with good pain relief. In August 2006, EMG/NCV study of the right lower extremity showed early sensory peripheral polyneuropathy. In January 2007 and February 2007, Dr. performed right L5-S1 ESI, which gave 50% pain reduction. In May 2007, M.D., performed a peer review and opined that the current treatment was reasonable and necessary; Lyrica and oxycodone were reasonable; and office visits every three to four months would be reasonable. Dr. repeated injections in May 2007. Dr. opined as follows: (1) The patient's current symptoms were related to the lumbar surgery and formation of scar tissue. (2) It appeared that the imaging (MRI and myelogram) was based upon increased subjective complaints, as opposed to any actual neurologic deficit. (3) Based upon the chronic symptoms, some form of pharmaceutical management would be required. (4) ODG indicated that up to four ESIs could be considered acceptable provided that the prior injections gave at least six to eight weeks of substantial benefit, which was described as 50-70% alleviation of pain.*

In December 2007, Dr. noted he had performed RACZ treatment x3 in 2003. He diagnosed lumbosacral radiculopathy and postsurgical epidural scarring; and refilled Lyrica and oxycodone. In February 2008, Dr. noted persistent low back pain radiating to the right leg in a dermatomal pattern. Examination showed positive straight leg raise (SLR) on the right. Dr. recommended authorization for right L5-S1 transforaminal ESI.

On February 20, 2008, initial request for lumbar transforaminal ESI was denied. Rationale: *The patient has had three or four ESI per year for the last few years. ODG guidelines stated ESI provides no long-term benefit and recommends no more than two for therapeutic treatment. This worker has had at least 11. Thus, the request does not appear to meet ODG guidelines.*

On February 27, 2008, Dr. recommended reconsideration of the two-level transforaminal ESI. Rationale: *The patient is undergoing active home exercise plan and while he has had multiple treatments he continues to work at a manual labor job. He has only had about three injections per year and this kept him at*

*work full time and full duty.*

On March 11, 2008 an appeal for transforaminal ESI was denied. Rationale: *Documentation does not support effectiveness of previous epidural steroids, like decrease in pain score, greater than 50% relief of six to eight weeks (per American Society of Interventional pain physician's Interventional practice guidelines page 6-9 and the ODG web based guidelines 2006), increase in activity, increase in function, increase in sleep, return to some form of vocation, decreased medical visits. Documentation does not support signs and symptoms that support definitive nerve root involvement. Documentation does not meet ODG criteria like confirming MRI (studies) or objective findings supporting radicular symptoms.*

In a medical dispute resolution report dated March 19, 2008, Dr. opined: *We are able to keep him at work full time and full duty with approximately three ESIs per year and I think this is medically reasonable and necessary. His physical examination supports under the ODG, the performance of an ESI given the fact that he had some weakness in his right L5 nerve root as well as positive right-sided SLR and CT myelogram evidence of nerve root compression. Also regional blocks are pain management procedures that should be done on patients up to three times a year under the ODG to relieve pain and keep the patient functional and this is noted in the ODG.*

On March 28, 2008, Dr. noted the patient was working full time. He refilled OxyIR and recommended an independent review.

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

*PATIENT WITH BACK AND LEG PAIN, POSITIVE NEURAL TENSION SIGNS, AND SIGNIFICANT RELIEF FROM PREVIOUS TREATMENTS WHO IS CURRENTLY WORKING. PATIENT IS A CANDIDATE FOR REPEAT ESI.*

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

**IF YOU ARE NOT UTILIZING THE ODG GUIDELINES YOU MUST STATE WHY, PER TEXAS DEPARTMENT OF INSURANCE.**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

**PER ODG:**

7) 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. ([CMS, 2004](#)) ([Boswell, 2007](#))

(8) Repeat injections should be based on continued objective documented pain and functional response

[Benzon, 1986](#)) ([ISIS, 1999](#)) ([DePalma, 2005](#)) ([Molloy, 2005](#)) ([Wilson-MacDonald, 2005](#)