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Notice of Independent Review Decision Amended

DATE OF AMENDED REVIEW: November 30, 2009

Date of initial review: November 25, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ESI L4-5 region

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

Diplomate American Board of Physical Medicine & Rehabilitation
Subspecialty Board Certification in Pain Medicine
Diplomate American Board of Electrodiagnostic Medicine
Member-ISIS, ASIPP

REVIEW OUTCOME

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

X Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI

- Utilization reviews (10/22/09, 11/02/09)
- Office visits (05/28/09 – 10/14/09)
- Diagnostics (05/28/09)
- E-mails (11/17/09)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who at the time of the reported injury also had an open claim from xx/xx/xx following a slip/fall in the bathroom. She did not seek medical treatment for the xx/xx/xx, injury until after her xx/xx/xx work incident.

PRE-INJURY RECORDS: In, the patient slipped in a large puddle of water , twisted her left ankle and fell onto the floor landing on her buttocks, right hip, and twisted her lower back. In the process, her head hit hard against the opposite wall bumping her head and straining her neck. Following the injury, the patient reported swollen ankle, soreness of the back, right hip bruising, soreness of the neck, and soreness of the bilateral shoulders. The patient self treated with Tylenol and Ace bandage as no medical care was provided at that time.

POST-INJURY RECORDS:

2007 – 2008: On xx/xx/xx, the patient was moving some boxes and in the process hurt her back and shoulders. She was treated at Medical Center and was diagnosed with neck sprain, lumbar sprain, and back contusion. X-rays of the cervical, thoracic, and lumbar spine were ordered and the patient was placed on work restrictions. Later, the patient was seen at Orthopedic Center for pain in the lower, mid, and upper back region, as well as for neck/shoulders pain. Her doctor had treated her with steroids and Arthrotec.

In xx/xx, she was laid off by the employer due to Workers' Comp injuries even though light duty was approved by the clinic.

In April 2007, magnetic resonance imaging (MRI) of the left shoulder revealed a new rotator cuff tear.

At Orthopedic Center, the patient was diagnosed with neck strain/sprain, thoracic strain/sprain, lumbar strain, bilateral shoulder pain, and cervical strain; treated with physical therapy (PT) for spine and complete left shoulder arthroplasty.

Per patient, Dr. evaluated her for injuries of back and shoulder and later referred her to Dr. for shoulder surgery.

Per patient, the carrier had fraudulently denied her ankle sprain and the right hip bruises and soreness following the xx/xx fall. Also, she noted in xx/xx, that the carrier had fraudulently denied her lumbar strain diagnosis even though she had landed on her buttock/lower back and pulled her back especially the lower back in the two incidents.

In May 2007, MRI of the left shoulder revealed rotator cuff tear and loss of motion. Her left ankle pain had resolved and her right knee was fine. She also reported that previously her right hip was replaced by Dr. at and she had a previous laminectomy at L5-S1 with full recovery performed following a 1987 auto accident.

In June 2008, Dr. referred the patient to Dr. for her left shoulder complaints.

In August 2008, Dr. assessed lumbar back pain and sciatica and ordered an MRI of the lumbar spine and electromyography/nerve conduction velocity (EMG/NCV) study of the left lower extremity.

In December 2008, Dr. evaluated the patient for low back pain.

2009: The patient had a total shoulder arthroplasty on January 14, 2009, performed by M.D., an orthopedic surgeon.

In February and March a total of 24 visits of PT were approved.

A March 23, 2009, report from M.D., indicated that she had knee problems for which surgery would be considered once the problem of the left shoulder had been resolved. She complained of low back pain and spasms. She was overweight and a hypertensive. Examination revealed tenderness across entire lower back with decreased range of motion (ROM) and pain down the left lateral calf and right lower extremity. There was generalized weakness to the leg and decreased sensation along the L5 dermatome on the left with slightly decreased left extensor hallucis longus. Straight leg raising (SLR) caused mainly back pain. X-rays revealed multilevel spondylosis and grade I spondylolisthesis at L4-L5. The diagnosis was lumbar radiculopathy.

In April, a request for six sessions of PT was approved. She had already by then completed 30 visits of therapy. In May, a request extension of the six visits was authorized due to medical complications.

In April, the patient was admitted at Medical Center emergency room (ER) where electrocardiogram (EKG), spinal tap, and pheochromocytoma tests were performed.

MRI of the lumbar spine revealed degenerative changes, facet degeneration at L3-L4 and L4-L5, disc bulging and degenerative changes as well as hypertrophic changes resulting into moderate focal stenosis at L3-L4 and L4-L5, grade I spondylolisthesis at L4-L5, postoperative changes at L5-S1, left lateral disc protrusion at L4-L5 and degenerative spurring at L5-S1 causing left foraminal compromise.

M.D., obtained an EMG/NCV study of the upper extremities which revealed mild median sensory neuropathy on the left.

In June, six sessions of PT to the lumbar spine were approved whereas a request for PT for the left shoulder was withdrawn.

Dr. noted persistent back pain radiating to the right hip, right lateral thigh, right knee, and just below to the right foot. Examination revealed tenderness over the trochanteric bursa. Dr. performed a steroid injection into the right greater trochanteric region.

In July and August, request for additional PT to the left shoulder was withdrawn and denied respectively. A request for four visits to the lumbar spine was approved. A PT reevaluation dated July 2, 2009, indicated that she had been receiving exercises, electrical muscle stimulation to the left shoulder. She had less pain with increasing functional ability.

In September, Dr. noted persistent pain in the left leg like electric shocks associated with numbness and tingling in the left foot. On the left side, it radiated down to the heel and then to the forefoot, and occasionally down to the right leg, buttocks, and the anterior lateral aspect of the leg. She had not had PT for her back and was currently taking Lasix as a diuretic. History was positive for right hip arthroplasty in 2005 and lumbar laminectomy 20 years ago. Dr. diagnosed lumbar radiculopathy and recommended PT. A prescription for PT three times a week was issued for the diagnosis of sciatica.

Dr. noted complaints of intermittent pain radiating down the left arm associated with tingling in the left arm from the shoulder to the hand with numbness to the thumb and index finger, and occasional middle finger with weakness. Review of systems was notable for incontinence and increased urinary frequency. Dr. diagnosed left shoulder severe degenerative joint disease (DJD) and recommended continuation of formal PT for symptoms of deltoid weakness and either brachial plexopathy or nerve irritation that was causing continued pain. A month later, Dr. noted ongoing pain and numbness in the hand. He opined that there was a probability of carpal tunnel syndrome (CTS) and referred her for further evaluation.

In September, a request and appeal for 12 sessions of PT to the lumbar spine were denied.

M.D., noted complaints of a shooting nerve pain starting in the axilla and radiating down the arm. Left hand pain was associated with numbness and tingling specifically located to the palmar side of the hand. Examination of the wrist revealed mild tenderness and positive Tinel's sign. Dr. diagnosed left CTS, placed her in a short-arm splint, and issued a prescription to undergo therapy.

In October, lumbar ESI at L4-L5 level was requested.

On October 22, 2009, M.D., denied the request for an ESI at the L4-L5 level with the following rationale: *"Office visit on October 14, 2009, with Dr. addresses upper extremity issues. There was no mention of back pain. Office visit October 8, 2009, and September 10, 2009, with Dr. addressed left shoulder pain. There was no mention of back pain. MRI impression on May 28, 2009, states degenerative changes with facet degeneration at L3-L4 and L4-L5. Disc bulging and degenerative changes as well as hypertrophic changes are resulting into moderate focal stenosis at L3-L4 and L4-L5. Grade I is noted at L4-L5. Postoperative changes are noted at L5-S1. There is left lateral disc protrusion at L4-L5 and degenerative spurring at L5-S1 causing left foraminal compromise. No electrodiagnostics of lower extremities were submitted. Request for lumbar ESI is not indicated per ODG recommendations and review of the relevant records. The patient does not exhibit objective physical examination findings of lumbar radiculopathy as required by the guideline. The patient does not have a recent EMG to suggest possible electrodiagnostic findings of radiculopathy. Based on these factors the request is not indicated."*

According to an October 23, 2009, E-mail, the patient clarified that severe back pain was reported to Dr. during the October 14, 2009, appointment. The doctor had clearly noted persistent back pain with radiation, numbness, and tingling down the left leg with pain score of 8/10. The injection of cortisone to the right

hip did help for four months. The patient also reported that Dr. noted “there was no mention of back pain and visits for upper extremities” was incorrect as he referred to Dr. reports for left shoulder (not referenced in Dr. diagnosis and there was a mix up of injuries and doctors). She noted Dr. diagnosis referred to low back and left leg as well as sciatica and lumbago and enthesopathy of the hip. With regard to the comment that there was no recent EMG, the patient clarified that Dr. had ordered an EMG but was not approved by the carrier. In August 2008, Dr. of recommended a cortisone injection at the lower back based on the EMG findings.

On November 2, 2009, D.O., denied the appeal for an ESI at the L4-L5 level with the following rationale: *“Per discussion with Dr., he stated his rationale for ESI is acquired spondylolisthesis at L4-L5 with low back pain and left leg pain. Based on the information provided, the documentation does not support signs and symptoms that support definitive nerve root involvement. Documentation does not meet ODG criteria like confirming MRI (studies). MRI shows multiple pre-existing findings from degenerative issues but no herniation documented or confirming EMG or objective findings on physical exam supporting radicular symptoms. In the peer discussion, PT and medications have been tried, but no documentation supporting initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).”*

Comments: Compensable injury includes only rotator cuff tear of left shoulder, strain of right shoulder, lumbar and cervical sprain/strain. CTS has been disputed.

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

The information reviewed indicates the patient has documented HNP on objective testing and clinical evidence of neurogenic radiculopathy. Based on ODG, the referral for ESI is medically appropriate and meets Guidelines for ESI x 1.

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, 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. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#))
- (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

required. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of 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.)

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES