MATUTECH, INC.

PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544

Notice of Independent Review Decision

DATE OF REVIEW: January 25, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar epidural steroid injection L4-5 CPT codes 62311, 77003, 72275, 62264

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Fellow American Academy of Orthopaedic Surgeons

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

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Texas Department of Insurance
- Utilization Reviews (12/04/09 – 12/18/09)

Indemnity
- Diagnostics (02/22/08 – 11/16/09)
- Office Notes (06/01/09 - 11/23/09)
- Reviews (11/24/09)
- Utilization Reviews (12/04/09 – 12/18/09)

M.D.
- Office notes (12/18/07 - 11/23/09)
- Diagnostics (01/14/08 - 11/16/09)
- Reviews (03/03/08 - 11/24/09)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was trying to restrain a 100-lb Labrador retriever. The dog pulled her across the wet floor. She slipped and fell flat on her back landing heavily onto the floor. The incident occurred on xx/xx/xx.

2007: On December 18, 2007, the patient was evaluated by D.C., for complaints of severe mid and low back pain with sharp pain and stiffness in her left hip and leg. X-rays of the thoracic spine were unremarkable. X-rays of the lumbar spine revealed decreased disc space at L2-L3 and L3-L4. Surgical hardware was clearly visible at the L5-S1 vertebral level. Dr. assessed injury to the lower back, left sacroiliac (SI) joint, and left lower extremity; prescribed physical therapy (PT) and chiropractic manipulations.

2008: Magnetic resonance imaging (MRI) of the left thumb was performed for history of dog bite to the thumb with pain and swelling. The MRI was unremarkable.

M.D., performed electromyography/nerve conduction velocity (EMG/NCV) study of the upper extremities for complaints of pain, numbness, and tingling in the left hand and fingers. The study was unremarkable. MRI of the lumbar spine was performed which revealed prominent metallic susceptibility artifact obscuring and distorting the anatomic detail of L4-L5 and L5-S1, mid to upper lumbar spine.

M.D., a designated doctor, noted the patient's history was remarkable for lumbar surgery in 2002 with hardware and inguinal hernia repair. She was utilizing Neurontin, Zanaflex, Ultram, and Ambien. Dr. did not find the patient to have reached maximum medical improvement (MMI) pending further imaging, evaluation by a spine surgeon, and appropriate treatment.

M.D., performed a required medical evaluation (RME) and noted the following treatment history: *Dr. referred the patient to Dr. for pain management. She had six weeks of physical therapy (PT) and was recommended SI injections. Dr. noted no radicular pain. She was recently diagnosed with lupus erythematosus and celiac disease.* Dr. opined that the patient was not a candidate for any gainful employment as she needed to be evaluated by a competent spinal surgeon. He felt there was a possibility of left hip problems in addition to her back and found clinical evidence of radiculopathy on the left. He recommended additional studies including an EMG and a myelogram computerized tomogram (CT). He also suggested that no further chiropractic manipulations be carried out.

A lumbar myelogram was obtained, showing no significant abnormality from T12-L1 through L4-L5. A 2.5 x 3.5 cm pseudomeningocele at the level of L5-S1 extended down distally to the S1-S2 level. Post-myelogram CT revealed a 2.5 x 3.5 cm pseudomeningocele at L5-S1 through S1-S2, and minor extradural indentations secondary to disc bulges at L2-L3, L3-L4, and L4-L5.

Dr. l performed a post designated doctor evaluation and noted the following treatment history: *The patient had a history of thumb injury in xx/xx for which she was treated with a splint, exercises, PT, Darvocet, and Medrol Dosepak. A functional capacity evaluation (FCE) was recommended. She was treated by Dr. who placed her at MMI on January 15, 2008, and assigned 1% impairment. In April 2008, she was seen by Dr. who suspected reflex sympathetic dystrophy*

(RSD) of the thumb and recommended stellate ganglion block. Dr. did not feel the patient was at MMI for her thumb pending further evaluation including a stellate ganglion block. He felt there was a possibility of complex regional pain syndrome (CRPS) involving the thumb.

M.D., PM&R, evaluated the patient for low back pain, rated at the intensity of 9/10. Examination was remarkable for antalgic gait with slight list on the left, very limited lumbar range of motion (ROM) in all planes with complaints of pain, focal tenderness with mild facet dysfunction at L3-L4 and L4-L5 bilaterally, tightness of the paraspinal muscles more prominent on the left, tenderness of the SI joints bilaterally, positive March test revealing dysfunction on the left with less mobility of the joint, positive drop test on the left, positive Gaenslen's test for bilateral SI pain, and positive Patrick's Maneuver for left SI joint dysfunction. Dr. assessed failed back syndrome and SI joint dysfunction and recommended SI joint blocks for diagnostic and therapeutic purposes.

2009: M.D., a designated doctor, noted the following treatment history: The patient has had six weeks of PT and one injection into her SI joint. She was seen by Dr., an orthopedic surgeon, following which she was continued on manipulations through November 2008 and was given SI joint block on the left. Dr. felt the patient was not at MMI as he needed Dr. notes be made available or the patient needed another orthopedic evaluation to determine whether or not surgery was necessary versus continued conservative treatment by a physical therapist and pain management.

In April, Dr. noted the patient was seen by Dr. in February 2009, at which time she was diagnosed with failed back syndrome with post lumbar surgeries and SI joint dysfunction and was prescribed Norco, Neurontin, and Ambien. Dr. felt the patient was not at MMI until NCV studies were performed to determine whether or not the patient was a surgical candidate.

In June, Dr. evaluated the patient for complaints of increasing unsteadiness navigating stairs and incontinence of bowel and bladder. The pain was rated at 9/10, sexual dysfunction, increased depression, and insomnia. Examination was remarkable for flat affect, depression, gait was bend forward, limited lumbar ROM in all planes, focal tenderness with mild facet dysfunction at L3-L4 and L4-L5 bilaterally, tightness of paraspinal muscles more prominent on the left, minimal tenderness at the SI joints bilaterally, positive Gaenslen's test and Patrick's maneuver. Neurological examination was remarkable for some weakness in the left foot dorsiflexor and extensor hallucis longus (EHL) muscles at 4/5, abnormal sensation in a non-dermatomal distribution in the left lower extremity. Dr. assessed failed back syndrome post lumbar fusion, SI joint dysfunction, and situational depression; ordered a CT myelogram of the lumbar spine, and referred the patient to Dr. for counseling regarding chronic pain and situational depression.

In July, Dr. opined that the patient had severe back pain and was in critical need of spinal surgical evaluation. The CT myelogram requested by Dr. should be done immediately. X-rays revealed stable appearance of lumbar spine compared to May 2004, and posterior element fusion at L5 and S1 with persistence of grade I spondylolisthesis.

M.D., an orthopedic surgeon, evaluated the patient for lumbar pain at the intensity of 9/10, ongoing numbness and tingling in the left lower extremity and down into her toes. Examination revealed discomfort lying on the examination table and difficulty upon movement, blunted patellar and Achilles reflexes bilaterally, tenderness in the lower lumbar region limited by severe pain, decreased ROM with flexion and extension limited by pain, positive straight leg raise (SLR) on the left, decreased motor strength on the left as compared to the right, and decreased sensation in the anterior thigh and lateral leg on the left, 2+ edema and erythema noted in the left ankle and shin, tenderness to touch around the lower ankle area, and a staggered gait. X-rays were obtained which revealed fusion and hardware present from L5 to S1 with good alignment. Dr. assessed lumbar radiculopathy, ordered a lumbar CT myelogram and EMG of the lower extremities, prescribed Lorcet, tizanidine, and Ambien; and referred her to her primary care physician (PCP) to rule out deep venous thrombosis (DVT).

CT-angiogram of the lower extremities revealed changes consistent with diffuse narrowing on either side proximally with either high-grade stenosis or occlusion of anterior tibial and peroneal arteries greatest on the left possibly suggestive of vasculitis. EMG/NCV of the lower extremities revealed evidence of acute left L4 radiculopathy, bilateral peroneal mononeuropathy of uncertain etiology, and right sural sensory mononeuropathy of uncertain etiology.

On November 23, 2009, Dr. recommended lumbar epidural steroid injection (ESI) for ongoing symptoms in her lower back with radiculopathy.

On November 24, 2009, M.D., performed a peer review and rendered the following opinions: There should be no functional impairment at this point. Any functional impairment that the patient has had would be due to the diseases of life from which she is suffering and not the effects of the alleged compensable injuries. The patient would have reached MMI by February 30, 2007. Her minor compensable work injuries would have resolved by that time. Ongoing complaints after that date would have been due to diseases of life from which she was suffering and not from the effects of the alleged compensable injuries. In regard to ongoing medication usage there was absolutely no indication for ongoing use of medications. The patient was not suffering from a compensable injury at the time. Norco could be gradually weaned off and discontinued after two weeks, Ambien could be given every other day for two weeks and then every third day for two weeks and then discontinued. Zanaflex and tizanidine were not recommended and could be stopped without weaning. The patient should be on home exercise program (HEP) and over-the-counter (OTC) medications. There was absolutely no indication for ongoing formal medical treatment.

On December 4, 2009, M.D., performed a utilization review and non-authorized the lumbar ESI with the following rationale: "*Patient has chronic low back pian. The patient has evidence of radiculopathy with weakness. According to ODG, ESI not medically indicated at this time. The patient will benefit from epidural injection if the pain is acute. The use of epidural steroids for chronic pain and radiculopathy is not clearly mentioned.*"

On December 18, 2009, M.D., non-authorized the appeal for a lumbar ESI with the following rationale: "*The records submitted revealed that patient is a female with a history of chronic back pain associated with numbness and tingling*

sensation in the left lower extremity. The patient has undergone back surgery in 2002. There is no clear indication that patient has received optimal conservative treatment such as medications, PT, and activity modification. Based on the physical examination last November 23, 2009, there were no noted clear dermatomal or myotomal patterns of affectation to signify possible nerve root pathology. There was no detailed examination to check for other possible pain generators in the affected region. Thus, the medical necessity of the requested injection cannot be ascertained at this time."

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

Request was for a lumbar epidural steroid injection at L4-5. ODG guidelines states the patient needs to have clear findings of radiculopathy. Radiculopathy as defined by ODG guidelines would be positive imaging studies with nerve root compression, pain along the nerve root distribution and findings of weakness, loss of reflex, muscular atrophy or loss of sensation. From reviewing the documentation, the patient does not have positive imaging studies of compression of the nerve root. Physical findings of radiculopathy are not present including specific weakness and/or loss of sensation in dermatomal pattern. I agree with the decisions of previous reviewers, Dr. and Dr.

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

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