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Notice of Independent Review Decision

DATE OF REVIEW: July 2, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injection under fluoroscopic to include CPT codes 62311, 72275

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

Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME

X Overturned (Disagree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Dr.

- Office visits (08/18/09 – 06/10/10)
- Diagnostic test (09/25/09)

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- Office visits (08/18/09 – 06/10/10)
- Diagnostic test (09/25/09)
- Utilization reviews (10/09/09 – 06/17/10)
- BRC decision report (03/15/10)

TDI

- Utilization reviews (06/03/10, 06/17/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work-related injury on or about xx/xx/xx. He was carrying a blower backpack for about 45 minutes. He turned and twisted to lay the backpack on the golf cart. Later, he drove to pick up his coworker, got off the buggy and felt spasms in the back. He worked the rest of the day and by the end of shift, he experienced increased back pain

M.D., a PM&R physician, evaluated the patient for back and hip pain and numbness to the left lower extremity. The patient had utilized Celebrex leftover from the previous injury. History was significant for non-insulin-dependent

diabetes and resolving discogenic low back pain in February 2008. Examination revealed decreased light touch discrimination over the left thigh with pain in the right hip. Dr. diagnosed low back pain and suspected herniated disc at L4-L5 and/or L5-S1 on the right. Dr. treated him with trial of Medrol Dosepak, Ultram, Celebrex, Naprelan, tramadol and Flector patches and physical therapy (PT) with some progress. The patient returned to work at light duty. However, he did not respond well to these conservative measures.

Magnetic resonance imaging (MRI) of the lumbar spine showed disc desiccation, broad-based disc bulge and bilateral facet hypertrophy at L5-S1 resulting in mild central stenosis. There was mild-to-moderate left-sided and minimal right-sided neuroforaminal narrowing and mild compression of both S1 nerve roots in the lateral recesses. Mild disc desiccation was noted at L3-L4 with mild facet hypertrophy.

Dr. recommended lumbar epidural steroid injections (ESIs).

On October 9, 2009, lumbar ESI was denied with the following rationale: *“Records reflect CC of severe central low back pain with occasional complaints of radiation into the right hip and groin. 12 PT are approved under the claim. Exam is without objective evidence of neurologic deficits. The physician note as late as September 29, 2009, documents negative SLR as well. The MRI findings document a L5-S1 central disc herniation with impression on both S1 nerve roots. MRI findings are not concordant with subjective complaints or clinical exam for S1 radiculopathy. ESI is not recommended without unequivocal evidence of specific radiculopathy. It is not recommended for acute low back pain and thus the request was denied.”*

On October 20, 2009, appeal for lumbar ESI under fluoroscopic guidance was denied with the following rationale: *“Based on the medical records submitted for review on the above referenced claim, lumbar ESI is not approved. ESI is being requested because claimant has had conservative care with minimal relief of symptoms. Lumbar MRI and PE finding are noted. Radiculopathy must be present to perform ESI (ODG). Claimant does not have radiculopathy. If this remains questionable, EMG/NCS study should be considered. Lumbar MRI – L5-S1 disc bulge with facet hypertrophy and mild-to-moderate bilateral NF narrowing. Both S1 nerve roots are mildly compressed. Office notes dated September 1, 2009, show LBP radiates to right hip. Reflexes – symmetric, SLR negative bilaterally, no atrophy. LBP with radicular symptoms.”*

In November 2009, Dr. noted the patient had improved some with his back pain. He rated his pain as 4/10. Currently, he was doing a home exercise program (HEP). Dr. refilled Naprelan and Ultram, instructed the patient on abdominal core strengthening and active back extensor strengthening. Per lift test, the patient was able to lift 20 lbs from the floor to the waist therefore he was released to work with restrictions.

In a benefit review conference (BRC) held on March 15, 2010, it was decided the compensable injury of August 12, 2009, extended to include a disc protrusion at L5-S1.

On May 18, 2010, Dr. saw the patient for low back pain rated as 7/10 radiating to the right hip. He was taking Celebrex as needed. Dr. continued Celebrex p.r.n. and referred him back for PT and ESI. Work status as tolerated, sedentary to light, part time or no work was suggested.

On June 3, 2010, the requested ESI was denied with the following rationale: *On May 18, 2010, the patient reported low back pain radiating to right hip. He was taking p.r.n. Celebrex. Examination revealed protuberant abdomen, limited flexion/extension with pain. He ambulated independently. He was recommended PT and ESI. MRI finding were reviewed. The claimant improved in November and December 2009 and was released to full duty. There was a gap in treatment of five months. Thus, based on medical records, the request was denied in absence of radiculopathy (ODG).*

On June 10, 2010, Dr. noted the request for ESI as well as PT was denied. The insurance company claimed the patient had 12 visits of therapy, but the patient claimed he had only six sessions. Dr. clarified over the false accusations made by the insurance company about return to work and discontinuation of medical treatment. Dr. stated that the patient was never released to full duty work and had not abandoned medical care. The patient had just limited medical care for the time being as he was not paid for the treatment and had limited money available to pay out of pocket. Physical examination revealed decreased weight bearing, left lower extremity with walking. Reflexes: ankle jerk grade ¼, symmetric, knee jerk right grade ¼, left grade 0/4. Anterior tibialis left grade 4/5. Assessment was low back pain, secondary to disk disruption, L5, S1 with radicular symptoms, left lower extremity. Dr. stated the reviewers were misinterpreting the facts regarding further treatment authorization and requested the patient to visit his attorney in regards the misinterpretations and non adherence to the conclusion of BRC. He recommended continuing conservative care and off work status for a month.

On June 17, 2010, appeal for an ESI was again non-authorized with the following rationale: *“The clinician is requesting ESI for this claimant, however fails to meet the criteria per Official Disability Guidelines for this procedure in that there must be independent objective evidence of radiculopathy presented which is not indicated with this claimant. Specifically, there is no evidence of loss of relevant reflex or muscle weakness or atrophy presented. Based on what has been presented and ODG requirements this request is not certified.”*

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

Based on the medical records the examinee has symptoms suggestive of an S1 radiculopathy and MRI confirms mild compression of the S1 nerve root with neuroforaminal narrowing. In my opinion the findings are consistent with ODG and standard of care and the ESI should be performed.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS