



Notice of Independent Review Decision
IRO REVIEWER REPORT

DATE OF REVIEW: 2/23/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for bilateral L5-S1 transforaminal epidural steroid injections (ESIs).

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

Texas licensed Physical Medicine & Rehabilitation physician

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> 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.

The previously denied request for bilateral L5-S1 transforaminal ESIs.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice of Utilization Review Findings dated 2/3/10, 1/15/10.
- Letter from Billing Specialist dated 1/21/10.
- Initial Patient Visit dated 1/6/10.
- Pre-Authorization Request dated 1/11/10.
- Functional Capacity Evaluation dated 12/11/09.
- Electrodiagnostic Test Results dated 12/9/09.
- New Patient Evaluation dated 12/9/09.
- MRI of the Lumbar Spine w/o Contrast dated 12/3/09.
- MRI of the Right Knee dated 12/3/09.
- MRI of the Right Elbow dated 12/3/09.
- MRI of the Cervical Spine w/o Contrast dated 12/3/09.
- Clinical Observations/Comments dated 12/2/09.

- Patient Evaluation dated 12/1/09-1/5/10.
- Worker's Compensation Verification dated 11/28/09.
- New Patient Evaluation dated 11/24/09
- Patient Chart Information dated 10/6/09.
- Examination Results/Lumbar Spine 3 Views dated 10/6/09.
- Exam Results-CT Scan Head/Brain Without Contrast dated 10/6/09.
- Emergency Medical Record dated 10/6/09.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: female

Date of Injury: xx/xx/xxxx

Mechanism of Injury:

Diagnosis: 724.3, Sciatica; 724.4 Lumbosacral Neuritis NOS.

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

This female, with a history of diabetes, sustained a work-related injury to her neck and back on xx/x/xx. The mechanism of injury occurred when her vehicle was rear-ended in a motor vehicle accident. The diagnoses were sciatica and lumbosacral neuritis. An X-ray of the lumbar spine and a CT of the head were done on the day of the accident. The X-ray of the lumbar spine revealed degenerative changes and the CT of the head was unremarkable. The patient was initially treated with therapy and medications by Dr. Dr evaluated the patient on 11/24/09, at which time the physical examination documented 5/5 muscle strength in the lower extremities (bilaterally), intact sensation to light touch and absent patellar reflexes (bilaterally). The recommendation was for cervical and lumbar ESIs. xxxxx, a chiropractor, performed / interpreted MRIs of the cervical and lumbar spine, right elbow and right knee on 12/3/09. The lumbar MRI report documented that there was a 3-4mm disc bulge at L5-S1 with effacement of the anterior surface of the S1 and L5 nerve roots and degenerative changes at from L3-4 to L4-5. The right knee MRI revealed medial meniscus tear, popliteal cyst, and grade 1 chondromalacia patella. On December 9, 2009, the patient was evaluated by Dr., at which time the patient reported that her elbow and knee pain had resolved and she had persistent neck and low back pain, along with tingling in the right upper extremity. The physical examination of the lumbar spine documented motor and sensation were completely intact with absent deep tendon reflexes (DTR). Electrodiagnostic tests were done at that visit and they revealed evidence of bilateral median nerve entrapment at the wrist (right moderate, left mild), and bilateral tibial neuropathy. There was no electrodiagnostic evidence of radiculopathy. A Functional Capacity Evaluation (FCE) was done on 12/11/09. At that time, the patient reported multiple pain complaints including, but not limited to, 5/10 low back pain and right knee pain. No radicular pain was documented. The physical examination

documented normal sensation (pin-prick, two-point discrimination, light touch, deep pressure, vibratory, temperature and proprioception). Also provided for review were 21 progress notes from xxxxxx dated 11/10/09 through 1/5/10. The objective findings documented tenderness and spasms. These notes documented that the patient was improving. On 1/6/10, Dr. evaluated the patient, at which time it was noted that the patient complained of intermittent low back pain. She stated that the pain no longer radiated into her legs, but did report bilateral foot pain that she felt was related to her back. At that time, she also reported intermittent neck pain with radiation into the hand. She denied any numbness, tingling or weakness in her arms or legs at that time, but reported she had had those symptoms in the past, after the accident. The physical examination was notable for a negative Spurling's, positive cervical and lumbar tenderness, decreased sensation to pinprick in the left L5 distribution and a positive right straight leg raise. The upper extremity reflexes were noted to 1+ bilaterally and the lower extremity reflexes appeared to be 0 bilaterally, but the specific reflexes tested were not documented. The recommendation noted that the patient was most concerned about her low back. A request was made for bilateral L5-S1 transforaminal ESIs. A question regarding the medical necessity of the requested bilateral L5-S1 transforaminal epidural injections has arisen. According to the ODG, *"Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy. Use for chronic pain: Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. Criteria for the use of Epidural steroid injections: (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."* The provided records did not document that this patient met the guideline criteria to proceed with an ESI, as there was no consistent objective evidence of a radiculopathy on the physical examination or evidence of a significant neurocompressive lesion. The records did not document that this patient had radicular symptoms. The records indicated that the patient's primary complaint, per the most recent notes with respect to her low back, was axial pain. It should be noted that there are no peer review studies that establish the efficacy of ESIs in the treatment of axial back pain. Regarding the objective clinical findings, there were clearly discrepancies in the various physical examinations. Dr., on 11/24/09, documented normal strength, normal light touch and absent patellar reflexes, and on 12/11/09, at the time of the FCE, normal sensation (including pinprick) was documented. Dr., on 12/9/09, documented strength and sensation were completely intact with absent DTRs (reflex levels not specified), and on 1/6/10, Dr. noted decreased pinprick sensation in the left L5 distribution, positive straight leg raise on the right and absent lower extremity reflexes (reflex levels not specified). Based on the evaluations, there was no clear or consistent clinical evidence for right and left L5 radiculopathies. Furthermore, an MRI of the lumbar spine revealed only a 2-3 mm disc bulge without significant neurocompression and the electrodiagnostic tests did not reveal any evidence of a lumbar radiculopathy. Based on the provided information and the medical literature, there is not a

medical necessity for proceeding with an ESI in this patient. Therefore, the recommendation is to uphold the previous denial for bilateral L5-S1 transforaminal ESIs.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010, Low Back – ESI, Therapeutic.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).