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Notice of Independent Review Decision

DATE OF REVIEW: September 2, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Second lumbar epidural steroid injection under fluoroscopy with IV sedation at right L5-S1

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.

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 the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Dr.

- f* Diagnostics (07/14/09)
- f* Office visits (04/05/10 – 08/12/10)
- f* Operative reports (06/01/10)
- f* Utilization reviews (07/19/10 –08/12/10)
- f* TDI (08/17/10)

attorney

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TDI

- f* Utilization reviews (08/17/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who experienced sudden pull in her back when her flight came to a hard landing on xx/xx/xx. Subsequently, she developed numbness and tingling down her right foot and leg.

Initially, the patient was treated conservatively with physical therapy (PT) and medications including nonsteroidal anti-inflammatory drugs (NSAIDs), muscle relaxants and narcotic analgesics, but it did not help.

Magnetic resonance imaging (MRI) of the lumbar spine revealed: (1) At L2-L3, a 2-mm paracentral disc bulge with mild ligamentum flavum and facet changes and minimal narrowing of the left neural foramen. (2) At L3-L4, a 2.5 mm broad-based disc bulge, mild ligamentum flavum and facet changes and mild narrowing of the foramen. (3) At L4-L5, a 2.5 mm disc bulge, ligamentum flavum and facet changes and mild narrowing of the foramen. The central canal measured 9 mm in AP dimension. (4) At L5-S1, a 2-mm disc bulge.

D.O., a pain management physician, noted persistent back, right buttock and right leg pain with depression and loss of sleep. She had a limping gait. History was positive for hypertension, rotator cuff surgery and two neck surgeries. Examination revealed decreased lumbar range of motion (ROM), moderate sciatic notch tenderness with a positive straight leg raise (SLR) on the right and right posterior superior iliac spine (PSIS) tenderness aggravated with a positive Patrick's test. Dr. diagnosed chronic back pain syndrome with right lumbar radiculopathy following high impact injury, lumbar protruding disc and questionable right sacroiliac (SI) joint arthropathy and generalized fibromyalgia pain syndrome. He gave her combination of Paxil and clonazepam along with Ultram and performed lumbar epidural steroid injection (ESI) at right L5-S1 on June 1, 2010. The patient responded favorably to the lumbar ESI, but Dr. stated that the pain would return as the blocks were not being performed in a timely manner. He gave samples of Savella and requested proceeding with the second ESI.

On July 19, 2010, the request for the second lumbar ESI on the right at L5-S1 was denied with the following rationale: *"This is a review for medical necessity for a second ESI of the right L5-S1 requested for this patient who had a work-related injury on. The patient had a previous ESI done at L5-S1, to which the patient responded favorably. However, there was no information encountered regarding the efficacy of the first injection in terms of decreased VAS, increased functionality/enhanced ADLs and decreased intake of medications. In addition, radiculopathy is not established as there are no exam findings in the dermatomal/myotomal distribution in the right L5-S1. At this juncture, medical necessity of the requested procedure is not fully supported by the clinical data presented."*

On July 27, 2010, Dr. stated that the patient had responded well to the first lumbar ESI. Unfortunately, she went out of town and had slipped re-injuring her back. This was an exacerbation for prior condition and the patient was finding her pain escalated. Dr. changed Ultram to Norco and added Lyrica. The patient complained of pulling sensation down her right leg with positive SLR and was walking with an antalgic limp and gait. Dr. opined that series of lumbar ESIs in conjunction with continued exercise would be the mainstay of conservative care and therefore appealed for the same. He added Klonopin for sleep.

On August 12, 2010, the appeal was denied with the following rationale: *“In the clinical notes provided for review, the patient presented with numbness and tingling down her right foot and leg. This is an appeal for second ESI at L5-S1 level. However, there were limited neurologic findings that will support radiculopathy at the requested level. There was no dysesthesia noted at the lateral aspects of the lower leg and heel and the middle back of the leg. There was also no abnormality noted at the long toe extensors (hallucis longus) and ankle plantar flexors (gastrocnemius). Furthermore, there was limited documentation regarding the efficacy of the first injection in terms of decreased VAS, increased functionality/enhanced ADLs, and decreased intake of medications. Given the lack of support in documents, the request is not substantiated.”*

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

The patient had an initial injection which met ODG criteria for having an ESI. The patient improved from the injection. Thus having a proven radiculopathy which improved should cause the continuation of such treatment.

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

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**