



Notice of Independent Review Decision

DATE OF REVIEW: 03/21/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Transforaminal ESI w/Fluoroscopic at L5-S1 Outpatient 64483, 64484, 77003, 99144

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

Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- 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.

Lumbar Transforaminal ESI w/Fluoroscopic at L5-S1 Outpatient 64483, 64484, 77003, 99144 – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar Spine MRI, M.D., 11/16/10
- Pelvis MRI, Dr. 11/16/10
- Evaluation, M.D., 12/03/10, 12/29/10
- Therapy Referral, Dr. 12/03/10
- Physical Therapy, P.T., 12/08/10
- Evaluation, D.O., 12/10/10
- Physical Therapy, P.T.A., 12/17/10, 01/03/11, 01/04/11
- Utilization Review Referral, M.D., 01/12/11
- Denial Letter, 01/18/11, 02/24/11
- Evaluation, Dr., 02/01/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient allegedly fell at work on xx/xx/xx while walking upstairs. She missed a step and fell over on her right side. A lumbar MRI scan was performed at the request of Dr. on 11/16/10. The MRI scan demonstrated a right L5-S1 paracentral disc bulge causing severe right spinal canal stenosis obliterating the right lateral recess.

The patient was evaluated by Dr. on 12/03/10, complaining of right leg pain, denying “any back pain at all.” Physical examination documented positive straight leg raising test on the right, made worse by ankle dorsiflexion. Straight leg raising on the left was negative. Physical examination documented normal strength and sensation to both lower extremities, bilateral normal knee reflexes, absent LEFT ankle reflex, and diminished right ankle reflex (it must be remembered that the disc herniation was on the RIGHT). Dr. noted the claimant had not had any physical therapy. He recommended continuation of hydrocodone, stopping Flexeril and Soma and starting her on Lyrica. He also recommended a lumbar epidural steroid injection. The claimant presented for an initial physical therapy evaluation on 12/08/10 at which time her chief complaint was listed as “lower back pain.” Physical examination documented normal strength in both lower extremities and normal knee and ankle reflexes bilaterally. Straight leg raising test was said to be positive, but no side was listed. Physical therapy was recommended for four weeks at a frequency of two to three times per week.

On 12/10/10 the patient was evaluated by Dr. who listed her complaints of not only low back pain but also right buttock and leg pain with a pain level of 6/10 “at best.” The pain radiated from the right buttock to the foot with associated numbness and tingling, but the claimant denied any weakness. Physical examination documented back and leg pain with both flexion and extension, significantly positive right straight leg raising, but normal strength, sensation, and reflexes in both lower extremities. Dr. noted the claimant had not yet started physical therapy and “despite this,” stated he recommended a right L5-S1 and right S1 transforaminal epidural steroid injection. A physical therapy progress note was provided on 12/17/10. The claimant’s pain level was listed as 8/10 with her only

complaint as being in the “low back region.” No mention of any lower extremity symptoms was made.

Dr. re-evaluated the claimant on 12/29/10, stating that her primary complaint was of leg pain from the buttock to the thigh. Physical examination documented positive straight leg raising test on the right but normal reflexes, strength, and sensation in both lower extremities. Dr. recommended continued therapy as well as epidural steroid injection.

A second physical therapy progress note was documented on 01/03/11, at which time the claimant stated she was “doing much better” and that her low back pain and discomfort had significantly decreased. Again, no mention was made of any lower extremity symptoms.

Another physical therapy progress note was provided on 01/04/11 at which time the claimant complained of only “mild discomfort” with intermittent lumbar pain. Pain level was said to be 0/10 after treatment.

On 01/12/11 Dr. ordered a right L5-S1 and right S1 transforaminal epidural steroid injection, but no progress note or evaluation was provided by the doctor. The initial physician adviser reviewing the request recommended nonauthorization of the procedure on 01/18/11, noting the non-specificity of the positive straight leg raising test without the number of degrees at which the test became positive and the lack of a dermatomal distribution of neurologic deficits consistent with L5/S1 radiculopathy.

On 02/01/11 Dr. saw the claimant for an initial evaluation, documenting her low back and right leg pain with a usual pain level of 8/10. Physical examination documented pain in the low back and right leg with both flexion and extension. Straight leg raising test was said to be positive on the right, but no specificity as to the number of degrees at which the test was positive. Similarly, nonspecific diminished sensation and strength was noted at “4/5” without any specificity as to which side or to what degree these deficits allegedly were present. Dr. again recommended right L5-S1 transforaminal epidural steroid injection as well as switching the claimant to gabapentin from Lyrica and recommending bilateral lower extremity electrodiagnostic studies.

A second physician adviser reviewed the request on 02/24/11, also recommending non-authorization of the procedure. He cited ODG Treatment Guidelines and noted that the number of physical therapy visits that had been provided to the claimant was not specified and that maximum pharmacotherapy had not been validated.

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

According to ODG Treatment Guidelines, lumbar epidural steroid injections are medically reasonable and necessary when there is radicular pain in a dermatomal pattern consistent with MRI scan findings, and physical examination or electrodiagnostic

evidence of radiculopathy consistent with MRI scan findings. Additionally, epidural steroid injections are considered medically reasonable and necessary after an appropriate trial of conservative treatment such as physical therapy. In this case, there is no documentation as to the number of physical therapy visits that have been provided to this patient. Moreover, the last physical therapy progress note clearly indicated that the patient had minimal to no pain, which would indicate that physical therapy had sufficiently relieved the pain and that interventional therapy would, therefore, not be needed. Additionally, the patient's most recent pain complaint was of pain radiating from the right buttock to the posterior thigh, which is not a pattern of pain radiation consistent with L5 or S1 dermatomal radiculopathy. Finally, most, if not all of the physical examinations documented on this patient documented normal strength, normal reflexes, and normal sensation or abnormalities in strength and sensation which were not specific as to the side of the finding nor the degree of the finding. Similarly, although straight leg raising test results have been documented as positive, the number of degrees of which the test was positive has never been documented, which is significantly important in determining whether the positive straight leg raising test is physiologically valid. Therefore, this patient does not, in my opinion, meet ODG criteria for the requested transforaminal epidural steroid injection. There is no documentation as to the amount of conservative treatment that has been provided, and current pain complaints are not consistent with a dermatomal pattern consistent with MRI scan findings. Additionally, physical examination evidence of radiculopathy is not clearly and definitively present. Therefore, the recommendations of the two previous physician reviewers for non-authorization of the requested lumbar transforaminal epidural steroid injection at L5-S1 are upheld. The requested procedure is not medically reasonable or necessary per ODG Treatment Guidelines as related to the work injury herein under review.

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

- ACOEM - AMERICAN COLLEGE OF OCCUPATIONAL & 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**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE &
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)**
- AMA 5TH EDITION**