
Notice of Independent Review Decision
IRO REVIEWER REPORT TEMPLATE –WC

June 27, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Injection to lumbosacral spine (62311), fluoro guide for spine injection (77003)
and drain/inject joint/bursa (20610)

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

**Board Certified Physical Medicine, Rehabilitation and Pain Management
Physician**

REVIEW OUTCOME:

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

X Partially Overturned (Agree in part/Disagree in part)

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

Provide a description of the review outcome that clearly states whether medical
necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Dr.

- Office visits (01/10/07 – 05/02/12)
- Diagnostics (05/16/07)

Dr.

- Diagnostics (05/16/07 – 04/07/11)
- Office visits (04/30/08 – 06/07/12)
- Procedures (08/07/08 – 08/19/10)

TDI

- Utilization reviews (03/08/12 – 04/30/12)

Sedgwick Claims Management Services Inc

- Diagnostics (05/16/07 – 04/07/11)
- Office visits (03/05/12 – 05/02/12)
- Utilization reviews (03/08/12 – 04/30/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a who was walking on xx/xx/xx. He stepped in oil on a lead-in-line and slipped and fell backwards injuring his lower back with pain radiating down the legs.

2000 – 2006: No records are available.

2007 – 2010: From January through August, , M.D., a neurosurgeon, evaluated the patient for lumbar disc problems. The patient reported ongoing pain radiating down both legs with numbness and weakness. There was progressive weakness and trouble walking as well as sexual dysfunction. The patient was utilizing Celebrex, Keppra, Darvon, Rozerem and amitriptyline. Dr. noted the following treatment history: *Initially, the patient was evaluated by Dr. and had discectomy in 2000 which was of no benefit. In 2001, the patient had repeat L4-L5 and L5-S1 posterior lumbar interbody fusion (PLIF) but the bone graft was rubbing the aorta and had to be redone on August 25, 2001. At that time, the colon was nicked in two spots and he had no circulation to the left leg. As a result he developed peritonitis and ended up becoming septic and had to undergo a colostomy and ileostomy and had an ileostomy bag for about two months. The patient was then referred to Dr. Rosenstein who obtained lumbar myelogram that revealed a left L5-S1 foraminal disc protrusion with laminal stenosis and pseudoarthrosis at L4-S1. He failed to respond to conservative care and on October 7, 2003, underwent pseudoarthrosis, L4-S1; radiculopathy at L5-S1 and disc protrusion. He had bilateral re-exploration of the laminectomy at L5-S1, excision of disc herniation and instrumentation and lateral gutter fusion from L4-S1. Dr. reviewed postoperative computerized tomography (CT) of the lumbar spine that showed L4-S1 fusion, some loosening of the right L5 and S1 pedicle fixation screws. Repeat flexion-extension views showed motion at L4-S1 in March 2004 but in August 2004, it revealed metal bony L4-S1 fusion in anatomic position. Repeat CT of the lumbar spine showed L4-S1 fixation with deterioration of the grafts at both levels and decreased fusion masses. There was possible loosening of the right L4 pedicle screw. Electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities from October 2004 showed bilateral L5 radiculopathy and S1 radiculopathy. Dr. diagnosed multiple lumbar discs, status post fusion multiple times and status post complications from lumbar fusion. He maintained the patient on Celebrex, Balacet, Skelaxin and Relafen, recommended physical therapy (PT) and evaluation by a different pain management physician.*

In May, Dr. obtained EMG/NCV of the lumbar spine that showed chronic lumbar radiculopathy involving the S1 nerve roots bilaterally and right L5 nerve root. There was mild-to-moderate axonal and demyelinating peripheral neuropathy indicated by reduced peroneal motor conduction velocity values. Repeat CT scan of the lumbar spine revealed expected postoperative appearance from laminectomies and posterior stabilization with metallic vertical rods and IP screws at L4-L5 and L5-S1, prior lower abdomen aortoiliac stent repair and suspicious osteoarthritis.

From March through November 2008, Dr. noted worsening back pain radiating down the legs with numbness and weakness, muscle spasms and progressive weakness and trouble walking. He maintained the patient on medications consisting of Ultram, Relafen, Skelaxin, Lunesta and Lyrica.

M.D., evaluated the patient for low back pain, bilateral buttock pain and hip pain. Dr. noted that the patient had attended a four-week pain management program in 2005. Dr. diagnosed failed lumbar back syndrome and lumbar postlaminectomy syndrome and recommended a trial of spinal cord stimulator (SCS).

M.D., performed permanent implantation of a Medtronic Octrode dual-lead SCS system after a successful trial. On follow-up, he noted severe limitations at work, severe limitation to lower body function, severe limitations to personal and household care, moderate limitations to upper body function, moderate limitations at social activities and sleep interruption due to pain. He treated the patient with bilateral trochanteric bursa injection.

From January through November 2009, Dr. maintained the patient on Darvocet-N 100, Celebrex, Skelaxin, Lyrica, Lunesta and discontinued Relafen and Ultram.

From January through June 2009, Dr. performed revision of dual SCS lead wire and administered trochanteric bursa injection and bilateral SI joint injection.

From September through November, Dr. evaluated the patient and noted that he was not doing well and the pain had returned in hips. Dr. administered bilateral facet joint injection and bilateral SI joint injection. The patient reported improvement in pain following those injections.

From January through December 2010, Dr. evaluated the patient for ongoing hip pain. The patient had limitations with upper body function, work, social activities, sleep, personal and household care and lower body function. Dr. treated him with bilateral SI joint injections and bilateral hip injection. The patient reported improvement in pain and was recommended conservative treatment. Dr. recommended continuing medication regimen consisting of Flexeril, Fiorinal and Lunesta.

2011: Dr. evaluated the patient for therapeutic drug monitoring. The patient reported worsening hip pain located below the hip along the femur. He ordered

CT scan of the right hip. On follow-up, Dr. noted that the patient was doing better after taking Norco. The patient complained of severe pain in the hips preventing him from sleeping well.

In April, Dr. obtained CT of the right hip that showed mild degenerative changes and postsurgical changes in the lumbar and femoral arteries.

On follow-up, Dr. noted that the patient was not doing well and had severe pain in the right hip. Dr. recommended right hip injection and CT scan of the lumbar spine.

From May through November, Dr. noted progressive weakness and trouble walking. The patient had muscle cramps aggravated by walking, sitting and standing. He maintained the patient on Flexeril, Norco and Lunesta. Later, he started Robaxin and Ambien.

From July through December, the patient had regular follow-ups with Dr. for ongoing lumbago and failed lumbar back syndrome. Dr. recommended continuing medications.

2012: In January and February, the patient was evaluated by Dr. for low back pain and bilateral lower extremity pain. The patient reported that he was utilizing eight Norco per day. Dr. diagnosed bilateral trochanteric bursitis, lumbago, lumbar spondylosis and lumbar postlaminectomy syndrome. He prescribed gabapentin and Roxicodone and recommended caudal epidural steroid injection (ESI) and bilateral trochanteric bursa injection.

Per utilization review dated March 8, 2012, the request for lumbar caudal ESI was denied with the following rationale: *"There is no documentation of a radiculopathy, which the guidelines recommend be present to proceed with the injection."* The request for bilateral trochanteric bursa injection was denied with the following rationale: *"The imaging study of the right hip indicates there are degenerative changes in the right hip. I see no clinical evidence to implicate the trochanteric bursa as being pain generators on either side."*

On follow-up, the patient reported increased difficulty with ambulation and worsening hip and back pain. The patient was unable to walk or stand without severe pain and was using motor chair in stairs. Examination of the lumbosacral spine revealed abnormal extension, pain elicited by motion and positive straight leg raising (SLR) on the left. Examination of the hips revealed pain elicited with ROM and reduced strength. Dr. refilled Roxicodone and recommended caudal ESI and bilateral trochanteric bursa injection.

Per reconsideration review dated April 30, 2012, the request for caudal ESI was denied with the following rationale: *"In this claimant there was a CT scan dated May 16, 2007, and no other recent imaging studies. There was an evaluation by Dr. on April 16, 2012, but there was no documentation of any radicular findings on*

PE except for a positive SLR on the left, but no abnormal neurologic findings noted. I called and spoke to CNP. No additional clinical was obtained. She stated she would bring the claimant back for a more complete PE. Based on this, the request is not supported by the ODG guides.” The request for bilateral trochanteric bursa injection was denied with the following rationale: *“The ODG does not address this request. M.D., author of Physical Medicine and Rehabilitation for Trochanteric Bursitis, recommends a step approach to treatment. Injections are supported if there is failure of conservative care with oral NSAIDs or PT. In this case there was no documentation of failure of either of these treatments. Therefore, it is not considered medically necessary at this time.”*

Dr. noted worsening back pain. Examination revealed difficulty getting out of the chair, decreased ROM in the lower back, decreased strength and positive SLR at 45 degrees bilaterally. Dr. refilled Ambien and Robaxin and ordered CT of the lumbar spine. He opined that the patient was 100% disabled and was unable to return to work.

In May and June, Dr. noted that the patient had increased left hip pain that was worse with sitting or standing. He refilled gabapentin and Roxicodone and scheduled follow-up in one month.

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

I disagree with the previous conclusion and denial of caudal ESI. The patient’s diagnosis is failed back syndrome with chronic bilateral L5 and S1 radiculopathies as documented per previous EMG/NCS. Patient is totally disabled and has chronic pain. Physical exam documented a positive left SLR, which documents a symptomatic radiculopathy. Per the ODG, the patient is in the therapeutic phase. In the therapeutic phase, repeat ESI/blocks should only be offered if there is at least 50% pain relief for 6-8 weeks with a general recommendation of no more than 4 blocks per year. The patient has chronic bilateral multilevel radiculopathy, thus a caudal ESI is a reasonable approach under fluoroscopic guidance. It is generally accepted to have updated imaging within 2 years prior to an epidural steroid injection. In this case, a Lumbar spine CT is appropriate and reasonable prior to the ESI due to the patient’s previous surgical intervention.

In regards to the trochanteric bursal injection, I recommend denial at this time pending response to caudal ESI. If the lateral hip pain does not improve after the ESI, then the greater trochanteric bursal injections are reasonable. The patient has had them in the past and responded successfully. Gait alteration associated with back pain/radiculopathy or static traction on gluteal musculature during rest therapy may be predisposing factors trochanteric bursitis. Documentation must include percentage of pain relief and duration.

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**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**

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES