

CALIGRA MANAGEMENT, LLC
1201 ELKFORD LANE
JUSTIN, TX 76247
817-726-3015 (phone)
888-501-0299 (fax)

Notice of Independent Review Decision

October 19, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection at L5-S1 with lysis of adhesions, 62311, 77003, 72275 and 62264

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

Board Certified Pain Management Physician

REVIEW OUTCOME:

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

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:

- Reviews (0808/13, 09/25/13)
- Utilization reviews (08/09/13, 09/26/13)

- Office visits (05/10/13 – 08/20/13)
- Therapy (05/22/13 – 06/28/13)
- Diagnostic (05/23/13)
- Reviews (0808/13, 09/25/13)
- Utilization reviews (08/09/13, 09/26/13)

- Office visits (05/10/13 – 08/20/13)

- Therapy (05/22/13 – 06/28/13)
- Diagnostics (05/23/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on xx/xx/xx, was working. He injured his head, upper back, mid back, low back and calf.

On May 10, 2013 the patient was evaluated for injury to the central head, upper back, mid back, low back and calf. The patient had pain. It was noted that the patient was seen at Regional and was treated initially with x-rays which were noted to be unremarkable. Examination of the spine showed tenderness to palpation, decreased range of motion (ROM) of the thoracic spine, mildly reduced lumbar spine flexion, right rotation, left rotation and mildly reduced cervical spine flexion. He had paraspinal muscle spasm of the right cervical area. Diagnoses were sprain and strains of the other and unspecified parts of back including neck, thoracic and lumbar spine, contusion of back and contusion of face, scalp and neck except eye(s). The patient was released to a trial of full duty and was to follow-up in one week.

On May 17, 2013 noted the patient's pain level was 7/10. He had been experiencing pain and decreased ROM. administered intramuscular (IM) injection of Toradol and refilled cyclobenzaprine and ibuprofen. recommended physical rehabilitation.

On May 22, 2013, the patient underwent PT evaluation.

On May 22, 2013 evaluated the patient for pain in the lumbar and cervical region. His pain level was 8/10. Examination of the cervical spine showed 2/4 triceps reflex, decreased sensation at C6 bilaterally and positive Spurling's test bilaterally. Examination of the lumbar spine showed painful tenderness at the greater trochanter and sacroiliac (SI) joint without pain on left and with pain on the right, mild muscle and limited ROM. There was decreased sensation in the right L5 distribution. Achilles reflexes were 1/4 on right and 2/4 on the left. X-rays of the cervical spine and lumbar spine were unremarkable. Diagnoses were sprain of neck, sprain of back NOS and left knee/lower leg contusion. The patient had suffered a painful injury to his lumbar spine and was prescribed medications including nonsteroidal anti-inflammatory drugs (NSAID), pain reliever and a muscle relaxer. started him on an aggressive course of physical therapy (PT) to help promote recovery and recommended magnetic resonance imaging (MRI) of the lumbar spine and cervical spine.

On May 23, 2013, MRI of the lumbar spine showed: (1) At L4-L5, there was posterior disc herniation by approximately 1.0 mm causing indentation of thecal sac. (2) At L5-S1, there was posterior disc herniation by approximately 1.8 mm causing mild narrowing of spinal canal and bilateral neural foramina.

MRI of the thoracic spine was unremarkable.

MRI of the cervical spine revealed: (1) Congenital block vertebrae at C2-C3 level with rudimentary intervening disc space. (2) At C3-C4, there was posterior disc herniation by approximately 2.0 mm causing mild narrowing of the spinal canal. (3) At C4-C5, there was posterior disc herniation by approximately 1.0 mm causing indentation over the thecal sac.

On June 17, 2013 evaluated the patient for pain, soreness and decreased ROM. The pain level was 7/10. The patient reported pain to the bilateral feet that radiated from lower back. The patient was recommended physical rehab that had been approved.

From June 25, 2013, through June 28, 2013, the patient attended three sessions of PT consisting of therapeutic activities and therapeutic exercises.

On July 22, 2013 evaluated the patient for cervical and lumbar region pain. His cervical pain level was 3-4/10 with no numbness or tingling. His lumbar pain level was 7/10 with numbness in the left foot. The patient reported feeling a pinch in his low back. He had pain in both heels with walking. Examination of the cervical spine showed mild spasm, tenderness and radicular pain in the bilateral shoulders and pericervical region, decreased sensation in the C6 distribution and positive Spurling's. Examination of the lumbar spine showed greater trochanter pain and tenderness bilaterally and SI joint tenderness with pain on right. ROM was decreased. There was decreased sensation in the S1 and L5 distribution on the right. Faber's test and Gaenslen was positive. Straight leg raise (SLR) was positive on right for leg pain to foot. SLR test was positive on left for back pain only. He had positive compression test on right. Diagnoses were lumbar disc displacement, cervical disc displacement and SI sprain. recommended additional PT. For persistent pain, the patient would be a candidate of a facet block on the right and left cervical region most noted at L5-L6 levels. Epidural steroid injections (ESIs) were indicated for treatment of the lumbar radicular pain. The radiculopathy had been unresponsive to prior PT, NSAIDs and muscle relaxers. discussed options including an SI joint injection for right SI joint pain.

Per utilization review dated August 9, 2013, the request for lumbar ESI with lysis of adhesions was denied with the following rationale: *"The guidelines indicate that for epidural steroid injection procedures, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and that the individual must be initially unresponsive to conservative measures. The MRI reported no nerve root compression. On physical examination, the claimant had mild weakness and no objective evidence of radiculopathy, with loss of relevant reflex or decreased sensation in a dermatomal distribution. There is no documentation of lower levels of conservative care of a home-based exercise program. The guidelines do not support lysis of adhesions as there is lack of significant literature. Based upon the medical documentation provided for review and the peer-reviewed, evidence-based guidelines, the request is not medically supported. The request for lumbar epidural steroid injection at L5-S1, with lysis of adhesions is not certified."*

On August 20, 2013 stated that the patient met all indications by ODG to proceed with a lumbar ESI. He resubmitted the request.

Per reconsideration review dated September 26, 2013, the request for lumbar ESI with lysis of adhesions was denied with the following rationale: *“The documentation submitted indicates that the claimant sustained an injury to the lumbar spine on xx/xx/xx. Per orthopedic report dated August 20, 2013, the provider reviewed MRI of the lumbar spine which revealed some mild compression along the left S1 nerve root which is consistent with physical examination findings including mild weakness and some loss of sensation as well as reflex change. The claimant underwent conservative care including physical therapy, oral anti-inflammatories, home exercises, and activity modifications. Per follow up visit report dated July 22, 2013, the claimant reports ongoing lumbar pain rated 7/10 with numbness in the left foot as well as pinching sensation in the back. On exam, there is tenderness and limitation of motion in the lumbar spine. There is decreased strength of right knee flexors and extensors graded 4/5. Achilles reflex on the right is 1/4 while the left is 2/4. There is decreased sensation at the right L5 and S1 distribution. MRI of the lumbar spine without contrast dated May 23, 2013, reveals a posterior disc herniation by approximately 1.3 mm causing mild narrowing of the spinal canal and bilateral neural foramina. The current request is lumbar epidural steroid injection at L5-S1 with lysis of adhesions, 62311, 77003, 72275 and 62264. Per phone conversation, designated representative, the claimant has reportedly sought for a change of treating physician. Had no medical documentation to support medical necessity for the requested procedure. At the present time, medical necessity for this specific request would not be supported per criteria set forth by Official Disability Guidelines, as there is no documentation to presently support the requested procedure to be one of medical necessity, as the claimant was previously essentially released from the case.”*

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

The patient has clear evidence of a lumbar disc herniation with neurological deficits which meet ODG criteria for an Epidural Steroid Injection.

However, there is no clinical evidence to suggest adhesions or scarring, thus the adhesionolysis is not medically necessary.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES