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Notice of Independent Review Decision

**IRO REVIEWER REPORT TEMPLATE –WC**

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January 14, 2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar epidural steroid injection under fluoroscopy with IV sedation

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

Board Certified Physical Medicine and Rehabilitation and Pain Management

**REVIEW OUTCOME:**

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

Overturned (Disagree)

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:**

**TDI**

- Utilization reviews (11/28/12, 12/12/12)
  
- Operative report (05/09/11)
- Diagnostics (05/08/12, 05/30/12)
- Office visits (06/29/12, 07/10/12, 11/12/12, 11/29/12)
- PPE (10/16/12, 07/05/12)
- Peer review (10/30/12)
- Utilization reviews (11/28/12, 12/12/12)
  
- Diagnostics (05/08/12, 05/30/12)

- Office visits (11/12/12 – 12/21/12)

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who on xx/xx/xx, slipped on ice and fell several times on his back on the ground over the course of two days.

On May 9, 2011, an orthopedic surgeon, performed left knee arthroscopic surgery.

On May 8, 2012, x-rays of the lumbar spine showed mild degenerative facet joint hypertrophy at L1-L2 and L2-L3 and moderate degenerative facet joint hypertrophy from L3-L4 through L5-S1. X-rays of the right ankle showed minimal degenerative hypertrophy at the right ankle joint.

On May 30, 2012, magnetic resonance imaging (MRI) of the lumbar spine showed: (1) Mild bilateral foraminal stenosis at L4-L5 and L5-S1. (2) At L4-L5, 2-mm bulge flattening the thecal sac without causing stenosis. There was an annular fissure in the posterior annulus of the bulge. The bulge caused mild bilateral foraminal stenosis at L4-L5. (2) At L5-S1, 2-mm abutting the thecal sac. There was an annular fissure in the posterior annulus of the bulge. The bulge caused mild bilateral foraminal stenosis at L5-S1.

On June 29, 2012, evaluated the patient for shooting, stabbing and throbbing low back pain associated with bilateral leg pain. The patient had tried physical therapy (PT), anti-inflammatories, pain medicines and steroid injections. Current medications included metformin, lisinopril and psych meds x2. The patient had an ataxic gait. Examination of the spine showed midline tenderness in the spine, decreased and painful range of motion (ROM) and positive straight leg raise (SLR). There was decreased strength of 4/5 noted in the anterior tibialis, extensor hallucis longus (EHL) and gastroc-soleus. diagnosed lumbar herniated nucleus pulposus (HNP) and discussed various treatment options with the patient. He recommended continuing with pain management and PT.

Per the physical performance examination (PPE) dated July 5, 2012, the patient showed moderate signs of decreased functional ability due to injuries to the left knee. The patient had reached a current physical demand level (PDL) of light medium. The evaluator recommended 10 days of outpatient medical rehabilitation program, eight hours per day, five days per week for four weeks.

On July 10, 2012, performed a psychological evaluation to determine the appropriateness of a chronic pain management program (CPMP). The patient's current complaints included lumbar discomfort while sitting. He was working part-time. The patient scored 15 on Beck Depression Inventory (BDI) indicating mild depression and 20 on Beck Anxiety Inventory (BAI) indicating mild anxiety. He was diagnosed with chronic pain disorder associated with both psychological features and general medical condition and was recommended entering into an interdisciplinary CPMP.

Per the PPE dated October 16, 2012, the patient was unable to safely perform his job demands. The evaluator recommended an active PT program. He recommended referral for consideration of injections in the area of injury, if the treating doctor felt it necessary.

On October 30, 2012, performed a peer review and rendered the following opinions: The diagnosis was thoracic strain/sprain, lumbar sprain/strain and post arthroscopic partial medial meniscectomy which was correct and supported by objective physical findings. The MRI findings of disc protrusion were unrelated. There were no records indicating that the patient had a torn anterior cruciate ligament (ACL). The patient's MRI showed evidence of a torn medial meniscus and a chondral lesion which was degenerative in nature. The medical condition would be totally resolved presently. The patient would be at pre-injury level and would need no additional future medical treatment, no durable medical equipment (DME), no medication, no PT, work hardening and would be able to return to work.

There are following additional records found in the peer review summary: *"The patient was evaluated in February and March 2011, who referred the patient to. The patient then underwent left knee arthroscopy with ACL reconstruction and was then referred for PT in July and November. An MRI of the left knee showed tear of the medial meniscus and evidence of chondral erosion of the medial femoral condyle with a degenerated medial meniscus. There were continued notes of PT. There was an independent medical review disability determination dated July 13, 2011. Diagnosis was post medial meniscal tear, chondroplasty. The patient had not reached maximum medical improvement (MMI) according to the conclusions of the independent medical exam doctor. There was a designated doctor exam dated September 17, 2011. The conclusion at that time was that the compensable injury was thoracic strain/sprain, lumbar strain/sprain and left knee. There were several records of work hardening program, PT and chiropractic records."*

On November 12, 2012, performed an initial pain management evaluation for complaints of chronic and persistent back, bilateral buttock and leg pain (left greater than right) below the level of the knee associated with numbness, weakness and tingling. The patient walked with an antalgic limp and gait. Examination of the lumbar spine showed decreased flexion at 60 degrees, moderate interspinous tenderness, moderate left greater than right sciatic notch tenderness with a positive SLR sign on the left at 60 degrees, contralateral SLR sign on the right at 80 degrees and mildly decreased pinprick sensation in the left L5 distribution. diagnosed chronic back pain syndrome with persistent left greater than right radiculopathy, disc protrusions at L4-L5 and L5-S1 with encroachment upon the neural foraminal nerve roots and L5 and S1 following work injuries. There were generalized deconditioning and myofascial pain following work injury, moderate reactive depression and insomnia associated with chronic pain state. prescribed Zantac, tramadol and amitriptyline and scheduled the patient for lumbar epidural blocks.

Per the utilization review dated November 28, 2012, the request for lumbar epidural steroid injection (ESI) with fluoroscopy and intravenous (IV) sedation was denied based on the following rationale: *“The Official Disability Guidelines, Low Back Chapter, states epidural steroid injections are recommended as a possible option for short-term treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy when used in conjunction with active rehab effort. Criteria for the use of epidural steroid injections note that radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. The patient also needs to initially be unresponsive to conservative treatment, exercises, physical methods, NSAIDs and muscle relaxants. Injections should be performed using fluoroscopy utilizing x-ray and injection of contrast for guidance. There is no recommendation for or against the use of IV sedation. This patient is being treated for chronic low back complaints with radiculopathy. The patient does have some mild decreased sensation in the L5 distribution. There is no indication of pain in a dermatomal distribution. The patient has had conservative treatment; however, the presence of radiculopathy is not corroborated by diagnostic studies. MRI shows no central stenosis, mild foraminal stenosis, however, no evidence of nerve root compression. Additionally, there is no documentation to support that an electrodiagnostic study has been done to show the presence of radiculopathy. It is also noted per case information that the patient has had an independent medical examination which indicated no further treatment was necessary. As guideline criteria have not been met in this case, medical necessity has not been established for a lumbar epidural steroid injection with fluoroscopy and IV sedation.”*

On November 29, 2012, evaluated the patient for chronic back pain and failed conservative, rehabilitative and medical treatment options with side effects. stated that the patient was still problematic. He had recommended a combination of amitriptyline at night and Ultram for daytime. The patient's MRI was consistent with disc protrusions and foraminal stenosis at L4-L5 and L5-S1. He continued to have a positive SLR on the left at 60 degrees with left leg pain below the level of the knee. He had decreased pinprick sensation preserved in the L5 distribution and was walking with an antalgic limp and gait. recommended a lumbar epidural block and scheduled the patient for this pending insurance authorization.

Per the reconsideration review dated December 12, 2012, the reconsideration request for lumbar ESI under fluoroscopy and IV sedation was denied based on the following rationale: *“In this case there is no documentation showing that this patient does suffer from radicular pain as confirmed by imaging studies. The patient may have undergone some PT but there is no documentation showing type or amount and what length of relief if any this provided. There is no clear documentation showing why this procedure would be beneficial to this patient. The documentation does not substantiate the request at this time. Therefore, an adverse determination is recommended.”*

On December 21, 2012, noted that the patient was walking with an antalgic limp and gait. Despite this he was working. Medications included tramadol and amitriptyline which were helpful. The patient was using NSAIDs on a p.r.n. basis. He had a positive SLR sign on the left and also lumbar disc protrusion at L4-L5 with radiculopathy. He was exercising and working on weight loss. He was referred by his surgeon for injection therapy. The patient was taking medicines compliantly and his urinalysis was negative for illicit drug use. suggested re-submitting the request for the injection therapy through the IRO process.

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

There is sufficient supporting data to include the MRI and physical exam(+SLR and decreased sensation in the L5 dermatome) to support the diagnosis of lumbar radiculopathy. The patient has completed all conservative treatment options to include physical therapy and medications. Therefore, the request for lumbar ESI should be approved.

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

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**