

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

Notice of Independent Review Decision

January 25, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar transforaminal epidural steroid injection bilateral L5 and S1 with anesthesia care by on call CRNA

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

Board Certified Physical Medicine and Rehabilitation/Pain Management

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.

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 (12/19/12, 12/27/12)

Gallagher Bassett Services, Inc.

- Diagnostic (08/07/12)
- Office visit (12/12/12)

Genex Services, Inc.

- Office visit (08/01/12, 12/12/12)
- Diagnostic (08/07/12)
- Utilization reviews (12/19/12, 12/27/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his lower back while lifting.

On August 1, 2012, XXXX D.C., evaluated the patient for low back pain. He had constant moderate inflexibility and restricted movement as well as achy pain radiating to the right and left lateral ankle. The pain was aggravated by bending and was rated as 8/10. Examination of the lumbar spine showed severe fixation at L1 to L5, severe pain at L1 to L5 bilaterally and severe spasm of the lumbar paraspinal muscles bilaterally. There were severe trigger points noted of the lower back. Examination revealed positive Bragard's sign, Kemp's test and Lasegue's test bilaterally. He had moderate-to-severe pain on thoracolumbar range of motion (ROM). There was weakness of hip flexors, medial rotators, gluteus maximus, quadriceps, gastrocnemius and tibialis anterior and slight weakness of hamstrings. Dr. XXXX obtained x-rays of the lumbar spine which showed right acetabulum measuring 25 inches shorter than the left and decreased disc space at L5-S1. The left ilium was superior. Dr. XXXX diagnosed displacement of the lumbar intervertebral disc without myelopathy, lumbar sprain, myofascitis and muscle spasm. He treated the patient with chiropractic treatment consisting of manual adjustment, manual therapy, kinetic activities, intersegmental mobilization and electrical stimulation.

On August 2, 2012, Dr. XXXX noted that the patient had significant improvement. The patient had medium level of pain at L1 to L5 bilaterally and moderate hypertonicity of the lumbar paraspinal muscles bilaterally. There were moderate trigger points. Dr. XXXX treated the patient with chiropractic therapy.

On August 7, 2012, magnetic resonance imaging (MRI) of the lumbar spine showed the following findings: (1) At L5-S1, a broad-based 4 mm central disc protrusion contacting the bilateral S1 nerve roots in the lateral recess and facet hypertrophy contributing to mild bilateral foraminal stenosis. (2) At L4-L5, a broad-based 3 mm central disc protrusion contacting the bilateral L5 nerve roots in the lateral recesses and facet hypertrophy contributing to moderate bilateral foraminal stenosis. (3) At L3-L4, a 2 mm disc bulge. (4) At L2-L3, a 1 mm disc bulge.

On August 8, 2012, the patient reported worsening of the lumbar pain. Dr. XXXX treated him with chiropractic therapy.

From August 9, 2012, through August 16, 2012, the patient was evaluated and treated by Dr. Tran with chiropractic therapy consisting of manual therapy, kinetic activities, electrical stimulation and supervised hamstring stretches.

On September 20, 2012, an unknown physician evaluated the patient for initial pain management assessment. The evaluator noted that the patient had tenderness, decreased and painful ROM and decreased sensation over L4, L5 and S1 dermatomes. He diagnosed lumbar radiculitis. The patient was prescribed Ultram and was recommended transforaminal epidural steroid injection (ESI) at L4-L5 and L5-S1. The report is illegible.

On October 8, 2012, M.D., performed a peer review. He noted following treatment history: *On XXXX, the patient was loading and while lifting heavy piece his back began to hurt. On July 31, 2012, XXXX evaluated the patient for upper and lower back pain radiating to the bilateral lower extremities. Examination revealed tenderness over the mid thoracolumbar region with bilateral lower extremity L4-L5 dermatome radicular symptoms, decreased torso ROM with flexion to 50 degrees, patellar DTR 2/4 bilaterally, quad strength at 5/5 bilaterally and positive SLR bilaterally with pain accentuated with cough. The patient was diagnosed with thoracolumbar strain with bilateral lower extremity radicular symptoms and was prescribed ibuprofen, cyclobenzaprine and Tylenol. The patient was instructed to use Biofreeze, ice packs and moist heat.* Dr. XXXX rendered the following opinions: (1) The patient's L5-S1 and L4-L5 disc protrusions were in all medical probability pre-existing based on the surrounding facet hypertrophy and bilateral foraminal stenosis both of which were degenerative conditions. The mechanism of injury (MOI) in all medical probability exacerbated the patient's underlying lumbar degenerative disc diseases (DDD). The other disc bulges at L3-L4 and L2-L3 were in all medical probability pre-existing as well and were not the source of the patient's current complaints. (2) No further chiropractic treatment was indicated per the ODG. Based on the medical documentation provided, the patient had received adequate chiropractic treatment per ODG for the compensable injury of a lumbar sprain. The patient had a positive straight leg raise (SLR) bilaterally which was an indicator of radiculopathy. Based on this finding and MRI, he should have been evaluated by an orthopedic spine specialist or neurosurgeon. If the orthopedic spine specialist or neurosurgeon's physical examination had a finding of radiculopathy then an ESI was indicated per the ODG. (3) Further treatment would be appropriate and medically related to the compensable injury.

On November 8, 2012, M.D., evaluated the patient for back pain radiating to the bilateral calves and bilateral thighs. The pain was burning in nature. The associated symptoms included spasms, tenderness and tingling in the legs. Examination of the lumbar spine showed maximum tenderness at the sacroiliac (SI) joint, decreased and painful ROM and pain on SLR. Dr. assessed sciatica, lumbar or lumbosacral intervertebral degeneration and spinal stenosis of the lumbar region. He prescribed Cymbalta, tramadol, propranolol and gabapentin and instructed and educated the patient on back exercises.

On November 12, 2012, Dr. noted that the patient's pain level was 8/10. The pain was persistent in nature and radiated to the back and right heel. It was discomforting, localized, piercing, sharp, shooting and throbbing. Dr. prescribed Cymbalta, tramadol, propranolol and gabapentin. He instructed and educated the patient on back exercises.

On November 26, 2012, Dr. noted that the patient's back pain was stable, burning but persistent. The pain radiated to the left and right foot. He had constant pulling. He had associated tenderness and tingling in the legs. Dr. recommended continuing medications and back exercises and referred the patient to Dr. for pain management.

On December 12, 2012, M.D., evaluated the patient for low back pain. The patient had 60:40 back to leg pain ratio. The left lower extremity symptoms predominated over the right lower extremity symptoms. The pain was located in the bilateral lower lumbar paraspinal regions and burning in nature. It was present intermittently, worse in the evening and was varying in intensity. The low back pain was better since its onset. He had diffuse bilateral lower extremity pain, burning in nature, present intermittently, worse in the evening and varying in intensity. Review of systems (ROS) was positive for spine pain, muscle pain, confusion, numbness or tingling, depression and loss of interest in pleasurable activities. Sensory examination revealed decreased pinprick in right S1 dermatome. Examination of the lumbar spine showed moderate muscle spasm in the right mid lumbar paraspinal musculature and point of maximum tenderness in the right lower lumbar paravertebral area. Dr. reviewed the MRI findings and assessed disc disruption without myelopathy at central L4-L5 and L5-S1 and radiculitis bilaterally at L5 and S1. He recommended continuing medications and lumbar selective nerve root block/transforaminal ESI bilaterally at L5 and S1.

Per utilization review dated December 19, 2012, the request for bilateral L5-S1 transforaminal ESI with fluoroscopy and monitored anesthesia by on call CRNA was denied by M.D., with the following rationale: *“ODG-TWC Low Back Procedure Summary last updated October 24, 2012, states that diagnostic epidural steroid injections are also referred to as selective nerve root blocks, and they were originally developed as a diagnostic technique to determine the level of radicular pain. Guidelines indicate SNRBs can help to determine pain generators when there is evidence of multi-level nerve root compression. In this case, imaging findings indicate potential nerve root compromise of the L5 and S1 nerve roots, however, there is moderate stenosis noted at the L5-S1 level as compared to mild stenosis at the L4-L5 level. Clinical findings discuss diffuse pain which is not in a dermatomal pattern; however, there is decreased sensation in the right S1 dermatome and slight weakness in the left extensor hallucis longus (EHL) (L5 dermatome). With greater pathology noted upon imaging at the L5-S1 level and corresponding dermatomal sensory loss, the request for SNRB at bilateral L5-S1 the treatment plan would be supported however, ODG also address sedation and indicates that there is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than*

ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. The general agent recommended is a benzodiazepine. While sedation is not recommended for facet injections (especially with opioids) because it may alter the anesthetic diagnostic response, sedation is not generally necessary for an ESI but is not contraindicated. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. Supervision services provided by the operating physician are considered part of the surgical service provided. In this case, the provider has requested monitored anesthesia care (MAC) during this procedure. The documentation does not support that this claimant has anxiety to support the request for MAC. Therefore, without a returned call to support and agreed upon modification of this request, approval of this request cannot be recommended.”

On December 26, 2012, Dr. noted that the patient had persistent back pain, aching in nature. He had associated tenderness and tingling in the legs and numbness and tingling in the posterior thigh down the left leg. Examination showed maximum tenderness at the piriformis and SI joint. He had active painful ROM. Dr. prescribed tramadol, Cymbalta and propranolol and recommended ROM exercises and light duty.

Per reconsideration review dated December 27, 2012, the appeal for bilateral lumbar L5-S1 transforaminal ESI with fluoroscopy and monitored anesthesia by on call CRNA was denied by M.D., with the following rationale: *“ODG supports epidural steroid injections in cases of documented radiculopathy with objective findings, correlated imaging evidence, and failure of conservative care to date. Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. There is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal. Routine use is not recommended except for patients with anxiety. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. In this case, the claimant presents with signs/symptoms, imaging findings and failure of conservative care that indicate bilateral transforaminal epidural steroid injections at L5-S1 with fluoroscopic guidance are reasonable and supported by guidelines. While the submitted documentation indicates that the claimant has a history of depression, there is no indication of anxiety or clinical rationale provided for the MAC in conjunction with the proposed procedure. The case was discussed at length with XXXX, assistant to Dr. XXXX. However, other than the claimant's documented depression, XXXX can find no notes to describe an anxiety condition. XXXX does speculate that the claimant may have a fear of needles, but there is no documentation that she can*

find to support this speculation. On discussion, there seemed to be no other avenue such as prior office visits to other providers or procedure reports that would support the MAC. Without the opportunity to discuss the specifics of this case with Dr. XXXX or to gain additional information which supports the MAC, a modified approval cannot be given. Therefore, recommend denial of the entire request due to lack of evidence for the MAC at this time.”

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

I agree with Dr. XXXX M.D. that the ODG supports epidural steroid injections in cases of documented radiculopathy with objective findings, correlated imaging evidence, and failure of conservative care to date. Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. However, according to the ODG on MAC (monitored anesthesia care), there is no evidence-based literature to make a firm recommendation as to sedation during an ESI. This is of particular concern in the cervical region. (Hodges 1999) Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. Supervision services provided by the operating physician are considered part of the surgical service provided.

Because the ODG has a lack of firm guidelines on sedation and it states that sedation is not generally necessary for an ESI but is not contraindicated, I recommend overturning the previous adverse determination.

**IRO REVIEWER REPORT TEMPLATE -
WC**

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES