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Notice of Independent Review Decision

July 1, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left epidural steroid injection (ESI) at L4-L5 and L5-S1

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:

Overtuned (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:

- Diagnostic (03/20/13)
- Office visits (05/02/13 – 06/10/13)
- Procedure (05/06/13)
- Utilization reviews (05/31/13 – 06/19/13)

- Office visit (05/16/13)
- Utilization reviews (05/31/13 – 06/19/13)

- Utilization reviews (05/31/13 – 06/21/13)

- Office Visits (03/14/13 – 06/14/13)

- Diagnostic (03/20/13)
- PT (03/27/13)
- Utilization reviews (05/31/13 – 06/19/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on xx/xx/xx, twisted and felt a sharp pain in his low back while trying to break up some concrete inside the building to put in some new lockers.

Per DWC-73 report dated March 14, 2013, the patient was seen, who diagnosed low back pain with sciatica and placed him off work.

Per DWC-73 report dated March 18, 2013, continued the patient off work through March 25, 2013 and recommended evaluation by the treating physician.

On March 20, 2013, the patient underwent magnetic resonance imaging (MRI) of the lumbar spine for low back and left lower extremity pain. The study showed the following findings: (1) At L4-L5, a bulge lateralizing mildly to the left laterally. There was a mild facet and moderate ligamentous flavum hypertrophy and mild circumferential mass effect on the thecal sac with greater mass effect in the subarticular lateral recess at the origins of the L5 nerve root sleeves. (2) At L3-L4, slight bilateral lateral annular bulging. There was mild ligamentum flavum hypertrophy, prominent posterior epidural fat and slight circumferential mass effect on the thecal sac.

Per DWC-73 report dated March 21, 2013, continued the patient off work due to his low back pain secondary to sciatica and referred him to an orthopedic surgeon for further evaluation.

On March 26, 2013, the patient was seen. He reported that on March 12, 2013, he was trying to break up some concrete inside the building to put some new lockers when he twisted and felt a sharp pain in his low back. He continued to work and had some difficulty sleeping at night. He came back to work the next day and his pain got worse. He had seen who referred him for an MRI. The patient was currently having pain in the left leg. He had been taking tramadol, codeine and Motrin. The patient reported that he occasional had problems with his stomach when he had spicy food. On examination, noted the patient walked with a limp, trying to get off the left leg as quickly as possible. He forward flexed only 10 degrees and hyperextended to 10 degrees. He was very sore down the left posterior buttock and into the left posterior thigh. There was decreased sensation at L5 and S1 distribution and definite decreased ankle reflex on the left. He could not do a toe raise on the left side because of severe pain. reviewed the MRI and noted degenerative disc disease (DDD) at L4-L5 and L5-S1. The quality of the films was suboptimal. There was a superimposed left disc herniation with inferior extrusion and mass effect on the left S1 nerve root, but this could not be appreciated on the films. diagnosed acute left S1 nerve root compression and prescribed Medrol Dosepak. He warned the patient about the gastric and emotional side effects. He put the patient off Motrin and sent him for physical therapy (PT). further opined that these

symptoms would resolve in six weeks, but the patient would ultimately need epidural steroid injections (ESIs) and possibly a lumbar surgical intervention. The patient was allowed to return to work with restrictions.

On March 27, 2013, the patient attended PT consisting of ice, electrical stimulation, therapeutic activities and home exercise program (HEP).

On April 9, 2013, re-evaluated the patient for his back. He had undergone four sessions of PT and overall felt that symptoms in his back and left leg had improved dramatically. The patient was on light duty. Examination revealed little pain along the left iliolumbar ligament and down the left posterior buttock with associated numbness in the L5 and S1 distribution on the left leg compared to the right. His ankle reflexes were decreased on the left compared to the right. Knee reflexes were equally brisk. The patient continued to complain of some achiness in his left calf. diagnosed acute S1 radiculopathy on the left and placed the patient on another Medrol Dosepak. stated that if the second Dosepak did not help his symptoms adequately, then he would send the patient for some ESIs.

On April 23, 2013, noted the patient had completed 10 sessions of PT but continued to have pain in the left leg that went into the left foot. He had leg weakness. The patient reported that it hurt when he walked. The patient was not working. The second Dosepak had helped him minimally. On examination, the patient continued to hurt in the left posterior buttock. When he sat down he complained of decreased sensation in the entire left leg and calf compared to the right. The ankle reflexes were decreased on the left compared to the right. Repetitive toe raise was weaker on the left. felt the patient would need surgical intervention. He referred the patient for some ESIs and requested a repeat MRI as the first one was of poor quality. He kept the patient on work restrictions.

On May 5, 2013, the patient was referred, for pain management. He complained of pain in the lower back and occasional pain in the posterior aspect of his left leg. The pain was rated at 7. The patient reported weakness, fatigue and sleepiness. He rated his job to be heavy. He was independent with his activities of daily living (ADLs), grooming and self care. The patient was utilizing naproxen. Examination revealed a guarded antalgic gait with slight list to the left. He was able to tip toe and heel walk without difficulty. Examination of the lumbar region revealed limited range of motion (ROM) in all planes, especially in extension and lateral bending with pain and discomfort. There was diffuse tenderness in the lower lumbar paraspinals, left greater than the right. The SI joints were tender to palpation, more on the left. The posterior superior iliac spines (PSIS) were asymmetric with the right slightly lower than the left. Gillette's test revealed dysfunction on the left with less mobility of the joint. Rock/open book test was positive on the left, Gaenslen's was positive for significant sacroiliac (SI) joint pain provocation bilaterally. Patrick's maneuver was positive for left for SI joint dysfunction and negative for gross hip joints pathology. Straight leg raise (SLR) produced pain in the left posterior thigh. Neurological examination was unremarkable. opined that the patient had a mixed picture of SI joint sprain and impressive findings on MRI of extruded disc

and left S1 nerve root impingement. These findings were probably related to the described mechanism of injury and explained the symptoms in his lower back and occasional pain in the left lower extremity. He diagnosed SI joint dysfunction and degenerative lumbar disc disease with extruded L5-S1 disc per MRI. He discussed the treatment including injections to the left L5 nerve root and the SI joints, appropriate PT and use of nonsteroidal anti-inflammatory drugs (NSAIDs). The patient was concerned about the nerve root block and was asking if SI joint injections could be started. stated that a course of PT would be needed after the injection to address soft tissue mobilization, strengthening of the core muscles, stretching and instruction in a home program. He prescribed Naprosyn.

On May 6, 2013, performed a diagnostic SI joint block of Kenalog and bupivacaine in each joint.

On May 16, 2013, the patient reported that he had received three to four days of complete relief after the injection, but the pain had returned with the same intensity. During the period of relief, he had called his job and requested return to work without restrictions. The patient reported persistent pain in the lower back and complained of weakness, fatigue and sleepiness. He rated his pain at 7/10. The patient stated that he had some relief from his HEP. assessed probable left L5 and S1 radiculopathy and scheduled the patient for left transforaminal ESI at L4-L5 and L5-S1.

Per utilization review dated May 31, 2013, the request for outpatient left ESI at L4-L5 and L5-S1 was denied, with the following rationale: *"This claimant was injured three months ago while using the jackhammer. Request is for ESI at L4-L5 and L5-S1. Note from May 16, 2013, shows claimant had SI injection with 100% pain relief. Claimant requested return to work. Claimant still has persistent back pain with limited range of motion or some extension and side bending. Tenderness is noted over the lower lumbar paraspinals. SLR is positive on the left. MMT is 5/5. SI joint are very tender. No current radicular signs are seen. Note from March 26, 2013, shows decreased sensation at L5-S1. Claimant cannot toe raise on the left. Previous treatment documented is PT and medication. Responses not documented. The request fails to meet ODG criteria in that the clinical does not unequivocally describe a radiculopathy on both physical examination and imaging/EDS. Therefore at this time and on this information request is not authorized."*

On June 10, 2013, the patient returned on an emergency basis for significantly increased pain in the lower back with radiation to the lower extremities as well as numbness and weakness. He rated his pain at 9/10 and was not able to perform his HEP. His medications were causing him gastric upset and he was not taking his medications unless he could not move. Examination of the lumbar region revealed a straightened lumbar lordosis, very limited ROM of the lumbar spine in all planes and a widespread segmental dysfunction from L2 through S1 segments. On palpation, there was diffuse tenderness in the lower lumbar paraspinal muscles, left greater than right. The SI joints were tender to palpation, more on the left side. Rock/open book test was positive on the left. Gaenslen's was positive for significant SI joint pain provocation

bilaterally. Patrick's maneuver was positive for left SI joint dysfunction and negative for gross hip joints pathology. SLR produced pain in the left posterior thigh. Manual muscle testing was suboptimal due to pain in his knee flexors, knee extensors, dorsiflexors and left EHL and was rated at 4/5. Sensation was globally abnormal in the left lower extremity. Reflexes were 2+ throughout. opined that the patient had a mixed picture of SI joint sprain and impressive findings on MRI of extruded disc and left S1 nerve root impingement. These findings were probably related to the described mechanism of injury and explained his symptoms in the lower back and occasional pain in the left lower extremity. opined that due to persistent pain and neurological deficits, it was reasonable to reconsider injections of the left L5 and S1 nerve roots.

Per reconsideration review dated June 19, 2013, the original decision of non-authorization of outpatient left ESI at L4-L5 and L5-S1 was upheld, with the following rationale: *"The claimant is a male who was involved in a work injury on xx/xx/xx, in which he injured his lower back while at work. The claimant underwent a course of 8 physical therapy treatments. The claimant underwent a SI joint block within 3-4 days of complete 100% relief that the pain returned with same intensity. On May 16, 2013, the claimant had a follow-up evaluation, for complaints of lower back pain at 7/10. It was noted that the claimant gets some relief from his home exercise program. An examination was performed that revealed positive orthopedic testing for the SI joint. Straight leg raise test produced pain in the left posterior side. Neurologically there was no gross deficit. Manual muscle testing is normal bilaterally at 5/5 throughout. Sensation is globally normal. Reflexes are 2+ throughout. In the impressions section it was noted that this patient has a mixed picture of SI joint sprain and impressive findings on MRI of extruded disc and left S1 nerve root involvement. The claimant was diagnosed with SI joint dysfunction, degenerative lumbar disc with extruded L5/S1 per MRI and probable left L5 and S1 radiculopathy. The recommendation was for a transforaminal epidural steroid injection at L4-L5 at L5-S1. This request was denied by peer review. submitted an appeal letter. The purpose of this review is to determine, on appeal, the medical necessity for the requested lumbar ESI. The medical necessity for the requested lumbar ESIs was not established. The requested lumbar ESIs not supported by ODG guidelines. A review of the examination dated May 16, 2013 from revealed no evidence of a radiculopathy. All orthopedic testing revealed positive clinical findings for a SI joint involvement. The only positive root tension sign was straight leg raise test and that produced the left posterior thigh pain. There was no evidence of a radicular component. The neurologic examination was normal. Given the absence of any radiculopathy on examination, the medical necessity for the requested lumbar ESI was not established."*

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

Patient has signs and symptoms consistent with lumbar radiculopathy and meets ODG criteria for lumbar epidural steroid injections. The diagnostic injections in the SIJ were positive but do not cause the physical signs of motor and sensory changes in the leg. Thus, the pain generator involves both the lumbar disc as well as the SIJ. This is in accordance with the ODG guidelines.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES