

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** JULY 2, 2013

**IRO CASE #:**

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

Medical necessity of proposed Caudal ESI-Lumbar (62311)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

### **REVIEW OUTCOME**

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.10	62311		Prosp	1			Xx/xx/xx	xxxxxxxxx	Upheld

TDI-HWCN-Request for an IRO- 21 pages

Respondent records- a total of 78 pages of records received to include but not limited to: TDI letter 6.14.13; letter 5.16.13, 4.4.13; records Dr. 2.6.13-6.5.13; records 3.12.13-4.11.13; MRI Lumbar Spine 3.11.13; Electrodiagnostic study 2.20.13

Respondent records- a total of 89 pages of records from Insurance received 7.2.13 to include but not limited to: records 1.18.13-1.31.13; records Dr. 2.6.13-6.5.13; records 3.12.13-4.24.13; MRI Lumbar Spine 3.11.13; Electrodiagnostic study 2.20.13; letter 4.4.13

Requestor records- a total of 57 pages of records received to include but not limited to: PHMO Notice of an IRO; patient demographics; records Dr. 2.6.13-6.5.13; records 3.12.13-4.11.13; MRI Lumbar Spine 3.11.13; Electrodiagnostic study 2.20.13; letters 3.18.13, 4.4.13, 5.16.13; IRO request forms; DWC form 73

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

The first medical documentation provided was a medical note from Dr., dated February 6, 2013. The medical note reports the injured employee was lifting a crate and felt a sharp pain in the lumbosacral junction on xx/xx/xx. The medical note reports the injured employee continued to work and later felt tightness in the neck and low back with pain radiating from the low back to the neck. She also developed radiating pain down the left leg and lateral thigh and calf with reported numbness, tingling and burning. The injured employee denied weakness or loss of bowel or bladder control.

The physical examination of the lumbar spine demonstrated the range of motion was full with pain. Motor strength was 5/5 in the bilateral lower extremities. Deep tendon reflexes were 2/4 in the bilateral lower extremities. Sensory was decreased in the L5-S1 distribution on the left. There was tenderness to palpation over the posterior superior iliac spine on the left and over the facets at L4-L5 bilaterally. There was a positive slump and FABER test on the left. The assessment was lumbago, thoracic or lumbosacral neuritis/radiculitis unspecified, spasm of muscle, pain in limb, and sacroiliitis not elsewhere classified. Dr. treatment recommendations were to refer for electrodiagnostic studies to evaluate for a lumbar radiculopathy. Neurontin and ibuprofen were prescribed, and physical therapy continued.

Electrodiagnostic studies of the lower extremities were performed on February 20, 2013, by Dr. The impression was electrodiagnostic evidence of bilateral mid to lower lumbar nerve root irritation indicated by increased insertional activity and spontaneous activity in the L4-L5 and L5-S1 lumbar paraspinal muscles bilaterally.

An MRI scan of the lumbar spine with and without contrast was performed on March 11, 2013, the impression, as reported by Dr., was:

1. Mild facet arthropathy, no disc herniation or compressive disc disease at L1-L2 or L2-L3,
2. Mild facet arthropathy, no disc herniation or compressive disc disease at L3-L4,
3. Moderate to severe facet arthropathy, very minimal spondylolisthesis, no frank neural encroachment, subtle retrodiscal enhancement noted without neural encroachment, perhaps related to prior intervention, nonspecific, at L4-L5, and
4. Mild degenerative disc disease, mild disc bulge, very subtle superimposed left foraminal to lateral foraminal protrusion and moderate facet arthropathy at L5-S1.

It was reported the injured employee underwent physical therapy from March 12, 2013, through April 24, 2013.

A summary review from April 4, 2013, for a non-certification of a caudal epidural steroid injection of the lumbar reported the injured employee currently used Elavil, ibuprofen, and

Neurontin. The mechanism of injury was a strain. The reviewer reported the physical examination of the injured employee showed there was no documented evidence of the injured employee objectively presenting with a radiculopathy. The provider documents recommendation for the injured employee to undergo a caudal epidural steroid injection; however, the guidelines indicate a radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Given the above, the request for the caudal epidural steroid injection of the lumbar was non-certified.

Dr., re-evaluated the injured employee on April 10, 2013, for continuation of care of low back pain. The medical note reports the injured employee had Neurontin increased to three times a day and had continued to use Elavil and ibuprofen. The medical note reports the plan was to proceed with a lumbar epidural steroid injection, but this was denied. The MRI scan demonstrated severe facet arthrosis at L4-L5 and a left L5-S1 lateral disc bulge with nerve root abutment in the far lateral recess. The electrodiagnostic study was demonstrated to show a bilateral L5-S1 radiculopathy. The physical examination demonstrated decreased sensation of the left lateral thigh and a positive slump test on the left. There was tenderness to palpation of the left posterior superior iliac spine and the lumbosacral junction bilaterally. Dr. treatment recommendations were to proceed with a caudal epidural steroid injection and continue current medications.

A reconsideration for an adverse determination letter dated May 16, 2013, reported the request for the caudal epidural steroid injection, lumbar, was not certified. The clinical information submitted for review failed to meet the evidence-based guidelines for the requested service. The mechanism of injury was loading a crate, and the injured employee strained her lower back. The injured employee had been treated with medications. Diagnostic studies, including electrodiagnostic study performed on February 20, 2013, reported left and right sural nerves had decreased conduction velocity. An MRI scan demonstrated moderate to severe facet arthropathy at L4-L5 and mild degenerative disc disease with a mild disc bulge at L5-S1. It was reported the injured employee underwent physical therapy.

The electrodiagnostic study report by Dr., reported the injured employee presented with low back pain that stemmed from a work-related injury. The injured employee developed pain radiating to the lateral thigh and calf muscles with numbness, tingling, and burning. The physical examination revealed 5/5 motor strength, negative Babinski's, positive slump test, and positive FABER test. The electrodiagnostic findings noted that needle evaluation of the left mid to low lumbosacral paraspinal muscles showed increased insertional activity and slightly increased spontaneous activity. The studies indicated evidence of bilateral mid to lower lumbar nerve root irritation. The physical therapy notes documented the injured employee demonstrated improvement with core stabilization and completed all activities without any increase in symptoms. The medical documentation presented for review continued to lack evidence to indicate the injured employee had a radiculopathy. In addition, the conservative treatments had not been exhausted. The injured employee was currently participating in physical therapy, and the most recent visit note of April 24, 2013, reported improvement without an increase in symptoms. Therefore, based on the above, the request for a caudal epidural steroid injection, lumbar, was non-certified.

Dr., re-evaluated the injured employee for continuation of care on June 5, 2013. The medical note reports the injured employee continued to have severe low back pain with radiation to the left lateral thigh and posterior thigh with numbness and tingling; and had completed physical therapy, but the pain remained severe. The injured employee continued to use Neurontin, Elavil, and ibuprofen. The physical examination demonstrated decreased sensation in the left lateral thigh with a positive slump test on the left. There was tenderness to palpation at the bilateral lumbosacral junction and tenderness in the left posterior superior iliac spine. There was a positive straight leg test on the left with decreased sensation in the L5 dermatome on the left. Deep tendon reflexes were 2/4 in the bilateral lower extremities. Dr. recommendations were to re-submit for the caudal epidural steroid injection and continue with current medications.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

**RATIONALE:** The medical documentation provided for review documented the injured employee had a strain/sprain to the lumbar spine. The MRI scan provided for review reported moderate to severe bilateral facet arthropathy and minimal spondylolisthesis with no disc herniation or frank compressive disc disease at L4-L5. At L5-S1 mild degenerative disc disease with moderate bilateral facet arthropathy, mild disc bulge, and a subtle superimposed left foraminal to far lateral protrusion was noted. The electrodiagnostic study reported increased insertional activity and spontaneous activity in the L4-L5 and L5-S1 lumbar paraspinal musculature bilaterally, which was suggestive of a bilateral lumbar radiculopathy; however, the electrodiagnostic study was not conclusive that there was a lumbar radiculopathy. The MRI scan did not corroborate the electrodiagnostic study of a bilateral lumbar radiculopathy, as the only evidence of any suggested nerve root impingement would be at the L5-S1 on the left. There was no documentation of any nerve root impingement at the L4-L5 or on the right at the L5-S1 level.

The current medical note from Dr., from June 5, 2013, reported a positive slump test on the left, tenderness to palpation of the bilateral lumbosacral junction, tenderness to palpation of the left posterior superior iliac spine, and a positive straight leg raise on the left, but there was no documentation of radiation and decreased sensation in the L5 dermatome on the left with normal deep tendon reflexes in the bilateral lower extremities. There has been no documentation of weakness with dorsiflexion of the toes or ankle on the left or in the right lower extremity which would be indicative of nerve root irritation in a primary L5 nerve root distribution.

The Official Disability Guidelines Low Back Chapter, updated May 10, 2013, reports lumbar epidural steroid injections would be supported if there was documentation of a radiculopathy on physical examination, corroborated by imaging studies or electrodiagnostic testing in individuals unresponsive to conservative treatment. Again, the physical and neurological examination findings along with the MRI scan and electrodiagnostic studies do not corroborate with each other. Based upon the medical documentation provided and reviewed, the medical necessity of the proposed caudal lumbar epidural steroid injection, level unspecified, would not be medically supported as a therapeutic measure at this time.

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES