

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** APRIL 29, 2013

**IRO CASE #:**

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

Medical necessity of proposed Transformational ESI L4-5 (64483) and Epidurogram (72275)

### **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 Occupational Medicine and Aerospace Medicine and is engaged in the full time practice.

### **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
724.4	64483		Prosp	1			Xx/xx/xx	13493577	Upheld
724.4	72275		Prosp	1			Xx/xx/xx	13493577	Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO-16 pages

Respondent records- a total of 51 pages of records received to include but not limited to: TDI letter 4.8.13; letters 3.1.13, 3.28.13; records 1.3.13-2.23.13; Radiology report 2.13.13

Requestor records- a total of 19 pages of records received to include but not limited to: TDI letter 4.8.13; records 1.3.13-2.19.13; Radiology report 2.13.13

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

1. Clinical note, dated January 3, 2013: Initial presentation: Claimant was in a vehicle (xx/xx/xx) when it was rear-ended by a vehicle going "highway speed", causing the vehicle to move about 20 feet. Claimant suffered almost immediate neck and low back pain. Claimant went to ED, where x-rays were taken; he was given Flexeril. Claimant was doing better after first 48 hours,--having no discomfort at time of initial clinic visit; he requested return to work. Claimant claimed no changes in lifestyle, family interaction, ability to do his job, nor any daily activities due to his injury.

PMH: discectomy L4-5, 2008; discectomy L5-S1, 2004; nonsmoker; rare alcohol.

PE: Positive findings: spasm of levator scapulae, trapezius, and scalenus muscles; rest of exam normal.

X-rays of cervical and lumbar spines: minimal anterior spondylolisthesis at C5, 6, 7; narrowing at L4-5, and L5-S1 (previous surgeries).

Assessment: neck and low back pain, improved.

Plan: return to full duty; return to clinic prn.

2. Clinical note, dated January 25, 2013.: Follow-up: Claimant with dysesthesia and pain down right lateral leg to right 5<sup>th</sup> toe; continues to work; problem not present prior to old back surgery.

PE: Positive findings: obese build; lumbar range of motion painful in extension (25% of normal); right leg touch abnormal at L5 and S1 dermatomes.

Assessment: lumbar radicular syndrome; (lumbosacral neuritis or radiculitis/ low back pain/neck pain).

Plan: EMG for right leg; gadolinium MRI; continue full duty.

3. Clinical note, dated February 13, 2013.: Follow-up: Continues with symptoms in right leg with numbness in outer part of right foot.

PE: Positive findings: none.

Assessment: right lumbar radicular syndrome; (lumbosacral neuritis or radiculitis/low back pain/neck pain)

Plan: EMG/NCS right lower extremity; follow up.

4. EMG of right lower extremity (February 13, 2013): no conclusive electrodiagnostic evidence of an active right lumbosacral radiculopathy or distal right lower extremity neuropathy.

5. MRI lumbar spine with and without contrast (February 13, 2013): Small right-sided laminectomy at L5-S1; enhancing granulation tissue within right side of spinal canal at L5-S1 surrounding right S1 nerve root; findings suspicious for small focal disk fragment within right side of canal (2-3 mm); 7 mm posterior disk protrusion at L4-5 with degenerative facet joint changes without central canal or neuroforaminal stenosis; anterior and posterior spondylosis at T12-L1, and L1-2.

6. Clinical note, dated February 19, 2013.: Follow-up: EMG negative. MRI with 7 mm herniation at L4-5, consistent with symptoms on lateral aspect of right leg to 5<sup>th</sup> toe.

Claimant has failed more conservative therapy, and is candidate for transforaminal ESI. Claimant asked re: surgery, but told we need to try ESI first. Previous surgery at L5-S1, with scar tissue, but current symptoms new pursuant to work injury—is inconsistent with new herniation at L4-5. Claimant continues to work full duty.

PE: Positive findings: obese; lumbar range of motion painful in extension (limited to 25% of normal); right light touch abnormal at L5 and S1 dermatomes.

Assessment: lumbar radicular syndrome due to herniated nucleus pulposus at L4-5; (lumbosacral neuritis or radiculitis/low back pain/neck pain).

Plan: transforaminal ESI at right L4-5.

7. Adverse Determination Letter, dated March 1, 2013, physician Advisor: indicated no PT to date since injury; ODG low back chapter recommends ESI in cases of objective

radiculopathy corroborated by imaging and/or EMG, unresponsive to conservative care (meds, exercise), no more than 2 levels, under fluoroscopy. Non-authorized because of lack of clinical information; submitted clinical documents do not note trial of physical therapy/exercise.

8. Adverse Determination Letter (Reconsideration), dated March 28, 2013, physician advisor: Based on medical records submitted for review, L4-5 steroid injection non-authorized; subjective complaints and physical exam prior to lumbar MRI consistent with lumbar strain without radiculopathy; EMG/NCS without evidence of radiculopathy; lumbar MRI indicated post-op changes at L5-S1, and right S1 nerve root; findings at L4-5 not consistent with physical exam, subjective complaints or EMG/NCS; no indication for epidural steroid injection in absence of radiculopathy. ODG criteria for ESI (purpose to reduce pain and inflammation, to facilitate progress of more active treatment programs, reduction of medication use, and avoiding surgery)—ESI alone offers no significant long-term functional benefit.; radiculopathy must be documented, with objective findings on exam, and corroborated by imaging studies or EMG testing.

**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/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

Determination: Right L4/5 Transforaminal ESI is not authorized.

Rationale:

According to the ODG TWC for Low back, therapeutic ESIs are recommended as a possible option for the short-term treatment of radicular pain, defined a pain in a dermatomal distribution with corroborative findings of radiculopathy, with use in conjunction with active rehab efforts; radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis; also, ESIs may lead to improvement of pain between 2 and 6 weeks after injection, but they do not affect impairment or function or the need for surgery, nor provide long-term pain relief beyond 3 months; there is no high-level evidence to support the use of ESIs for acute low back pain without radiculopathy.

The basic initial criteria for the use of ESIs are as follows:

1. radiculopathy must be documented; objective findings on examination must be corroborated by imaging studies and/or electro- diagnostic testing;
2. the claimant must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDS, and muscle relaxants).

A review of the available medical records does not reveal any trial of conservative treatment, less the flexeril originally prescribed in the ED. The available medical records reveal no trial of exercises, physical methods or even NSAIDS.

The most important factor, in disallowing this request, is there is no documentation of a radiculopathy. The claimant, after a review of the available medical records, does not have a radiculopathy. The EMG/NCV testing was negative. The only evidence the requestor gives for a radiculopathy is some subjective dysesthesias over the L5/S1 dermatomes. The AMA Guides to the Evaluation of Permanent Impairment, 5<sup>th</sup> edition, (these guidelines are used for all workers' comp claims in Texas), indicates a radiculopathy is a "significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness, and/or paresthesias. A root tension sign is usually positive. The diagnosis of herniated disk must be substantiated by an appropriate finding on an imaging study. The presence of findings on an imaging study in and of

itself does not make the diagnosis of radiculopathy. There must also be clinical evidence....” Such as loss of reflexes, and muscle atrophy as measured with a tape measure at identical levels on both limbs (the difference between the two limbs should be 2 cm or greater), in addition to pain.

One last factor, against authorizing the treatment, is the requestor indicated the claimant has a herniated nucleus pulposus, as per the MRI. This is not accurate, in that the MRI only indicated a “disk protrusion”, which is not the same as a herniated disk. Disk protrusions frequently are “normal findings”, and frequently resolve by themselves. A herniated disk is not a normal finding, and does not resolve by itself. It is a pathological disruption/rupture of the disk that does not normally resolve.

In summary, there is no documented evidence in the available medical records to support the need for a transforminal ESI. Consequently the request must be denied.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)