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Notice of Independent Review Decision

August 26, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

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:

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:

- Utilization reviews (07/09/13, 07/26/13)
- Office visits (08/09/12 – 07/11/13)
- Therapy (01/25/13)
- Utilization reviews (07/09/13 – 07/26/13)
- Office visits (08/09/12 – 07/11/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his back on xx/xx/xx.

No records are available from June 2009 through June 2012.

On July 16, 2012, the patient was evaluated. The patient complained of pain in his bilateral shoulders, right groin and low back with radiation into his right lower extremity. He stated that his pain was constant and rated it as 8-9/10, increasing to 10+/10. The pain was described as throbbing, stabbing, shooting and sharp sensation that was aggravated with walking, sitting and in the morning. It was noted that after the injury the patient was driven back to the company and taken to Southwest emergency room (ER) where he had x-rays of his back and computerized tomography (CT) scan of his head. A magnetic resonance imaging (MRI) was performed showing torn rotator cuff in both shoulders as well as lumbar discs. His groin injury was ignored and finally they had to have his right scrotum removed in September 2009. He underwent a left shoulder rotator cuff repair in 2010 followed by therapy. The patient did not have any surgery for his right shoulder. He had individual therapy, one injection into his lumbar area with benefit and a designated doctor evaluation (DDE) with 28% impairment rating (IR). He had a peer review that recommended he have a discogram, electromyography/nerve conduction velocity (EMG)/NCV and possible surgery in both shoulders. He had been referred to a neurosurgeon, pain management and an orthopedic surgeon for possible shoulder surgeries. He had also been referred for EMG/NCV and a discogram. He continued to follow-up with an urologist and had been approved for a lumbar epidural steroid injection (ESI). Currently he was utilizing Ultram, Zolpidem, trazodone, metaxalone, meloxicam, tramadol HCL, Lidoderm patch and Viagra. The patient had been unable to work since his injury and had to use a cane or a walker for ambulation. On examination, the right lower extremity sensation was decreased to light touch. Bilateral upper extremity and right lower extremity strength was decreased secondary to pain at 4/5. Patellar reflex was 1+ on the right. Examination of the lumbar spine showed tenderness and spasm of the bilateral erector spinae, bilateral gluteus and bilateral piriformis muscles. There was decreased range of motion (ROM). The right shoulder tenderness to palpation of the levator, supraspinatus and rhomboid and upper trapezius muscles. There was increased pain with ROM. On the left shoulder there was tenderness to palpation of the deltoid, supraspinatus, teres major, rhomboid and upper trapezius muscle. There was increased pain with ROM. The diagnoses were bilateral shoulder pain, bilateral shoulder internal derangement, bilateral shoulder rotator cuff tear, bilateral shoulder adhesive capsulitis, low back pain, lumbar disc/radiculopathy, right groin/scrotal injury and myospasm. recommended participation in post injection therapy three times a week for two weeks as well as additional therapy for active ROM three times a week for four weeks. The patient was to follow up.

On August 9, 2012 noted the patient had steroid injections to the right L4-L5 and L5-S1 with 80 to 90 % relief for two weeks with gradual return of the pain. The patient had started postinjection therapy, but was having radiation of the discomfort and pain into the right posterolateral thigh and calf involving the right big toe. On examination, the lower back was tender to palpation over the right L4-L5 and L5-S1. Straight leg raise (SLR) was positive on the right but negative on the left. Touch sensation was reduced in the right lateral calf and right lateral malleolus. Deep tendon reflexes (DTRs) was reduced to 1+ in the right Achilles

as compared to the left. There was tenderness to palpation of the bilateral shoulders, right worse than left. diagnosed bilateral shoulder internal derangement, lumbar radiculopathy and right groin scrotal injury. He scheduled the patient for a second lumbar ESI to the right L4-L5 and L5-S1 under fluoroscopic guidance.

On September 28, 2012, noted that the patient had seen a psychiatrist and had been referred for individual psychotherapy. He complained of right scrotal pain and signs of erectile dysfunction. He was receiving Viagra from his urologist. The low back pain continued with discomfort and stiffness with radiation into the right leg. The bilateral shoulder also hurt. Meloxicam help reduce the pain while amitriptyline improved his sleep. On examination, the neck showed reduced left lateral radiation, tenderness to palpation of the posterior aspect and tenderness to palpation of the bilateral upper extremity. The lower back examination showed tenderness of the right L4-L5 and L5-S1, positive SLR on the right but negative on the left and reduced touch sensation in the right lateral calf and right lateral malleolus. referred the patient to his urologist for further evaluation and treatment of right scrotal pain and erectile dysfunction. The patient was encouraged to see his psychiatrist and psychologist and to continue physical therapy (PT) and home exercise program (HEP). Amitriptyline was refilled and a request was placed for the lumbar ESI.

On October 2, 2012, wrote a letter regarding his psychological evaluation. She stated the patient's scores on the postconcussion symptoms inventory were extremely high. His self report on the Beck Anxiety Inventory (BAI) and Beck Depression Inventory-2(BDI-2) indicated extremely severe levels of depressive and anxious symptomatology that was consistent with his profile. The patient had an unusually high score on the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) suggesting a risk of opioid abuse. His Millon Behavioral Medicine Diagnostic (MBMD) profile suggested low risk of misuse of opioid medications, however. She stated that his pre-injury Global Assessment of Functioning scale (GAF) score was at 84 while his current GAF was 54. The patient had acknowledged to having thoughts of suicide but that he would not act on them. She stated that the patient had been strongly recommended a medical evaluation to determine benefit from a course of antidepressant. Also he was to be evaluated by a neurologist and/or a neuropsychologist due to ongoing symptoms possibly caused by a previous concussion.

On November 1, 2012, noted that the patient had a followup with neurosurgeon who recommended PT and possible steroid injection before considering lumbar surgery. The patient complained of pain, discomfort, and stiffness in his lower back with radiation into the right posterolateral thigh and calf. He had weakness in the right leg and tingling sensation. recommended initiating PT to the lower back, continuing psychotherapy with the psychologist and continuing amitriptyline and Flexeril. A request for lumbar ESI was to be placed to compliment his PT.

On November 29, 2012, noted that the lumbar ESI had been denied by the insurance company. The patient continued to complain of discomfort, pain,

stiffness in his lower back with radiation to the right posterolateral thigh and calf. He had weakness in the right leg and some tingling sensation. Medications had limited benefit. On examination, blood pressure was 154/90. The neck examination revealed left lateral cervical radiation with mild tenderness to palpation of the posterior neck. Bilateral shoulders showed tenderness to palpation of the anterior, posterolateral and anterolateral aspect of the shoulders. There was tenderness to palpation of the right L4-5 and L5-S1 and the right sacroiliac (SI) joint region. SLR was positive on the right but negative on the left while DTRs were 1+ in the right ankle. recommended continuing psychotherapy with the psychologist, tramadol and to await approval of the lumbar ESI to compliment the patient's HEP. The patient was also advised to make an urgent visit to his primary care physician (PCP) for treatment of high blood pressure.

2013: On January 8, 2013, and January 24, 2013, noted that the patient had started the chronic pain program. He was very motivated but was exhausted most of the time after intense physical exercise in the program. The program helped with his sleep and he occasionally needed amitriptyline. recommended continuing the chronic pain management program (CPMP), continuing the psychological and nutritional strategies taught in the program and gradually reduced his analgesics.

On January 25, 2013, a CPMP treatment review indicated that the patient had completed 10 sessions of CPMP. He had been compliant and had made progress in the program. The goal of the treatment was to discontinue the use of trazodone, metaxalone and zolpidem tartrate by the end of 20 sessions. Pain had decreased from initial 8-10/10 to 5-6/10. The plan of treatment was to provide additional 10 sessions of this program.

On February 21, 2013, noted that the patient continued to improve in the CPMP. He continued to use psychologic strategies especially for sleep at night and did not take amitriptyline every night any longer.

He had more soreness in the right lower back due to intense exercise. On examination the patient walked with a mild antalgic gait and used a cane to assist in ambulation. He was not currently wearing a back brace. recommended continuing the CPMP as well as psychologic and nutritional strategies. Tramadol was to be reduced to two times a day.

On February 28, 2013, indicated that the patient would be finishing his CPMP today. He was able to sleep adequately and did not use amitriptyline as much. Pain and discomfort in the lower back and shoulder had reduced to 5-6/10. There was moderate tenderness to palpation of the right L4-L5 and L5-S1 and the right SI joint region. recommended continuing the CPMP strategies and undergoing a functional capacity evaluation (FCE) in order to be referred to disability department of assistive rehabilitative services (DARS) to help him to return to work.

On the same day a clinical psychologist noted that the patient had completed 20 pain management sessions at Chiropractic & Rehab, five times per week for eight hours per day. After attending the program, the patient had increased his activity level significantly, both in treatment and at home. She recommended continue Prozac and four more individual therapy sessions.

On April 18, 2013, recommended that the patient's prognosis was fair and he was to follow-up for possible injections for his lumbar spine to follow-up with DARS. Due to his pain and functional limitations, the patient was unable to sit, stand or walk for prolonged periods of time.

noted that the patient continued to have severe ache, pain, discomfort and stiffness in his lower back with radiation into the right posterolateral thigh. His low back pain level was 6/10. recommended continuing HEP and keeping the appointment with DARS job placement. The patient was to continue amitriptyline to help with the neuropathic aspect of his pain and discomfort and to help with sleep.

On May 16, 2013, stated that the patient was undergoing an HEP. He was awaiting placement by DARS to be placed in a job. His FCE had placed him at a light work category. He continued to complain of severe aches, pain, discomfort and stiffness in his lower back with radiation into the right posterolateral thigh. He denied any bowel or bladder dysfunction. He was using cane to assist ambulation. recommended continuing the HEP and keeping the appointment with DARS job placement. Tramadol was to be discontinued and short-term hydrocodone 10/325 mg would be prescribed. The patient was recommended to have a urine drug screen (UDS) and he was to continue amitriptyline 25 mg.

On June 13, 2013, noted that the patient continued to undergo HEP. The patient had seen DARS program director and he started the 30-day program. The patient continued to complain of severe pain rated as 8/10 in his lower back with radiation into the right posterior lateral thigh. The patient had 50 % pain and discomfort reduction with use of hydrocodone. His activities of daily livings (ADLs) had improved. He continued to have severe pain in the bilateral shoulders. Examination of the bilateral shoulders showed moderate tenderness on the anterior and posterior lateral aspect of bilateral shoulder, abduction to 140 degrees bilaterally, forward flexion to 160 degrees and internal rotation to 60 degrees. Examination of the lower back showed mild tenderness on palpation of the right L4-L5 and L5-S1 on the right SI joint and positive SLR at 75 degrees in the sitting position. DTRs were 1+ on the right and 2+ in the bilateral knees and ankles. refilled amitriptyline and recommended continuing HEP and using the psychologic strategies that was taught during the chronic pain program to help sleep without medication.

On July 3, 2013, a preauthorization request was submitted for set of lumbar ESI injection at L4-L5 and L5-S1.

Per utilization review dated July 9, 2013, the request for ESI at L4-L5 and L5-S1 was denied with the following rationale: *“The history and documentation do not objectively support the request for repeat lumbar ESIs at this time. There is no evidence of radiating pain that is consistent with radiculopathy on physical examination and no EMG demonstrating radiculopathy has been reported. No focal neurologic deficits consistent with radiculopathy have been documented. There is no MRI of the lumbar spine demonstrating nerve root compression in the file. The claimant had some pain relief in the past from ESIs but the amount of relief and the duration do not appear to be optimal enough to support repeat injections. It is not clear whether the claimant has exhausted all other reasonable treatment for his ongoing symptoms or whether he has been involved in an ongoing rehab program. The medical necessity of this request has been clearly demonstrated and a clarification was not obtained. Based on the clinical information submitted for this review and using the evidenced-based, peer-reviewed guidelines reference above, this request for lumbar ESI at L4-L5 and L5-S1 is not certified.”*

On July 11, 2013, stated that the patient had returned to his clinic for low back and knee pain and stiffness. He was undergoing HEP, as formal PT had not been approved. He continued to complain of severe ache, pain and discomfort in his lower back with radiation into the right posterolateral thigh and calf. Pain was reported to be constant and he had to use a cane to assist in ambulation. He was utilizing three to four hydrocodone per day with 50% pain relief, two to three amitriptyline 25 mg at night to get six hours of sleep. On examination, the patient walked with a mild antalgic gait. He used a cane for ambulation. Blood pressure was 140/98. On examination of the lower back, there was moderate tenderness to palpation of the right L4-L5 and L5-S1 and the right SI joint region. SLR was positive at 60 degrees in the sitting position but negative on the left. There was reduced touch in pinprick sensation in the right L5 dermatome. DTRs were 1+ in the right ankle but 2+ in the left ankle and bilateral knees. recommended continuing HEP and another session of PT for the patient. The patient was to follow-up with the DARS program for job placement. Amitriptyline 50 mg was prescribed to help with neuropathic discomfort and pain at night. stated that the patient would benefit from right L4-L5 and L5-S1 transforaminally, as he had radiculopathy with dermatomal and DTR deficits. He also had previous PT that did not significantly improve his condition and was currently on analgesic program.

Per utilization review dated July 26, 2013, the appeal for ESI at L4-L5 and L5-S1 was denied with the following rationale: *“This male patient with date of injury of xx/xxxx. There is no MRI report to review. The patient currently has right leg pain with reduced right SI DTR. There is no MRI nor did the prior ESI provide any duration of benefit to qualify as a therapeutic injection, so repeating it is not indicated. Based on the clinical information submitted for this review and using the evidenced-based, peer-reviewed guidelines reference above, this request for an appeal ESI at L4-L5 and L5-S1 is not certified.”*

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

The patient had an ESI which met criteria for validity. The repeat injection is consistent with ODG because there was partial relief from the first injection. Thus, the request for repeat injection meets ODG criteria. Care should be taken from the perspective of the physician to ensure that the general health of the patient (ie blood pressure) is not a relative contra indication at the time of the procedure.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES