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Notice of Independent Review Decision

January 2, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right L5-S1 ESI (#3 injection)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Diagnostic (10/04/12)
- Office visits (11/21/12 - 10/24/13)
- Injections (04/05/13, 07/19/13)
- Utilization reviews (10/07/13, 10/29/13)

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- Office visits (02/07/13 – 09/19/13)
- Injections (04/05/13, 07/19/13)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who was climbing off a truck on xx/xx/xx. He injured his low back while doing that and experienced pain that radiated into his right lower extremity.

2012: On October 24, 2012, the patient underwent magnetic resonance imaging (MRI) of the lumbar spine at the Imaging for back pain since the work injury. MRI of the lumbar spine showed: (1) Moderate thecal sac stenosis at L3-L4 secondary to 3-mm generalized disc bulging. (2) Moderate thecal sac stenosis at L4-L5 secondary to slight grade I anterior subluxation of L4 on L5. (3) 6-mm disc osteophyte complex and moderate facet arthrosis at L5-S1 resulting in mild thecal sac stenosis and mild-to-moderate bilateral neural foraminal stenosis.

On November 21, 2012, evaluated the patient for back and left knee pain. It was noted that the patient had been evaluated and had been diagnosed with lumbar pain and lumbar disc degeneration. He had an electromyography (EMG) that revealed bilateral L5 radiculopathy that was both acute and chronic and that correlated to the foraminal stenosis seen on the MRI. The patient stated that he had tingling in his toes and feet bilaterally. reviewed the diagnostic studies to include EMG and MRI of the lumbar spine. He also reviewed MRI of the left knee dated September 4, 2012, that revealed cartilage degeneration with grade IV chondral fissuring in the far posterior medial femoral condyle. He diagnosed left knee cartilage degeneration with grade IV chondral fissuring in the medial femoral condyle with improving resolution of pain, degenerative disc and joint disease, lumbar spine; L3-L4 disc herniation with annular tear, L4-L5 lateral recess stenosis and bilateral foraminal stenosis, L5-S1 severe disc spondylolysis, foraminal stenosis, modic endplate changes at L5-S1. recommended continuing Mobic, hydrocodone and Flexeril and starting therapy. also recommended right L5-S1 epidural steroid injection (ESI) per EMG.

2013: On February 7, 2013, evaluated the patient for low back pain and right lower extremity pain. The patient also complained of numbness in his right leg and “could feel as though his leg was asleep”. He had cramping in addition in his right leg. He rated his pain at 4/10 and described it as throbbing. He had undergone PT which had helped to some extent. Examination of the lumbar spine showed decreased range of motion (ROM), pain with forward flexion, 5-/5 motor strength for right hip flexors, knee extensors, dorsiflexors, plantar flexors and long toe extensors. There was lower lumbar spine tenderness. Straight leg raise (SLR) was positive on the right but negative on the left. diagnosed lumbar radiculopathy, lumbar intervertebral disc displacement and lumbar spinal stenosis. He scheduled the patient for an L5-S1 lumbar ESI.

On February 7, 2013, the patient underwent urine drug screen which was negative.

On April 5, 2013, performed L5-S1 lumbar ESI.

On April 18, 2013, noted that the injection had helped with the patient's low back pain as well as right lower extremity pain. The cramping he had in his right leg had resolved. He continued to have numbness in the fourth and fifth toes of his right foot. discussed with the patient and recommended following up for reevaluation.

On June 4, 2013, evaluated the patient for back and left knee pain. It was noted that the patient was working light duty. His therapy for core conditioning was helping him. He was utilizing Flexeril, tramadol, Motrin and hydrocodone. He wanted to pursue a second injection since it had helped him. continued Flexeril, tramadol, Motrin and hydrocodone and scheduled right L5-S1 ESI per EMG. If the patient's symptoms would continue then a computerized tomography (CT) myelogram could be considered.

On July 19, 2013, performed L5-S1 lumbar ESI.

On August 1, 2013, the patient reported that he had got additional relief from the injections dated July 19, 2013. However, he still had symptoms of stiffness in his lower back after prolonged sitting. His pain level was 4/10. He was undergoing physical therapy (PT) which he reported was helping. recommended follow-up and follow-up as needed.

On August 27, 2013, evaluated the patient for back and left knee pain. The patient stated that he had the second ESI and also therapy and it helped him. He stated that he had completed a core program for strengthening. He was told that he might need a third injection. He continued to work on light duty. recommended a third right L5-S1 ESI and continuing Flexeril, tramadol and Motrin. The patient was to continue therapy for core conditioning.

On September 19, 2013, evaluated the patient for low back pain and right lower extremity pain. The patient reported that he had followed up with his treating doctor who had recommended additional third lumbar ESI in addition to PT. He had improved with his treatment regimen. Overall, the patient reported that he was about 60% to 70% better after the injection and therapy. He still had occasional cramping in his right calf as well as some numbness in his fourth and fifth toes of his right foot. He rated his pain as being 3-4/10. scheduled the patient for third L5-S1 ESI.

On October 2, 2013, a preauthorization request for an outpatient procedure to include lumbar ESI at L5-S1 was sent.

Per the utilization review dated October 7, 2013, the request for lumbar ESI L5-S1 was denied based on the following rationale: *"The records available for review document that previous treatment has included treatment in the form of two lumbar epidural steroid injections. The above noted reference supports treatment in the form of two epidural steroid injections in the therapeutic phase of treatment. As a result, presently, for the described medical situation, the above noted reference would not support this specific request to be one of medical necessity*

based upon the medical documentation presently available for review. Peer-to-peer discussion was unsuccessful."

On October 24, 2013, evaluated the patient for back and left knee pain. felt that the patient had obtained a very good positive pain reducing response from previous ESI x2 at the L5-S1 level and had a request for third injection denied without a medical criteria provided for the denial. The denial was made on the basis that was not available for the peer review telephone call. There was really nothing to respond in terms of rationale medical reason for denying the request. would pursue right L5-S1 ESI appeal to denial. He recommended continuing PT.

Per reconsideration review dated October 29, 2013, the appeal for lumbar ESI L5–S1 was denied based on the following rationale: *"The ESI is not supported as the last exam had no positive neurologic or radicular findings. The normal exam does not support doing an ESI as per ODG criteria. Peer-to-peer discussion was unsuccessful."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The patients neurological exam is not adequately documented as being abnormal. The percent relief from prior injections is not adequately documented.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**