

CALIGRA MANAGEMENT, LLC
1201 ELKFORD LANE
JUSTIN, TX 76247
817-726-3015 (phone)
888-501-0299 (fax)

Notice of Independent Review Decision

December 10, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Epidural steroid injection at L4-L5

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:

X 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:

- Diagnostics (08/21/13, 10/10/13)
- Office visits (09/04/13 – 10/28/13)
- Therapy (09/20/13 – 10/25/13)
- Utilization reviews (10/04/13, 11/04/13)

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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is female who on xx/xx/xx, reported increased back pain later that day. The following day, she noticed severe low back pain.

On August 21, 2013, the patient underwent magnetic resonance imaging (MRI) of the lumbar spine without contrast. The clinical history was lifting injury, low back pain and left leg pain. The findings were as follows: (1) Small intraforaminal disc herniation at L4-L5 on the left. Disc material mildly encroaching the inferior neural foramen but did not appear to displace or compress the exiting left L4 nerve root or ganglion. (2) Moderate degenerative disc space narrowing at L3-L4 without associated disc herniation, spinal stenosis or nerve root compression. (3) Mild left-sided facet arthropathy at L5-S1.

On September 4, 2013, evaluated the patient for left-sided low back pain and radiating leg pain. The patient reported severe pain over the weekend and took Aleve, Tylenol and her husband's tramadol. She was seen and prescribed a tramadol and muscle relaxers. She was then seen by an occupational medicine physician and was prescribed oral steroids without benefit. A lumbar spine MRI was ordered which demonstrated a disc herniation. recommended a neurosurgical appointment. History was positive for torn left rotator cuff in 2010. The patient stood with a right trunk shift. Left lateral flexion and extension reproduced radiating left leg pain. Lumbar flexion was 25 degrees producing leg pain. Sitting straight leg raise (SLR), slump test and supine SLR all reproduced left leg pain. Motor testing demonstrated weakness with left foot dorsiflexors. Femoral nerve stretch test was positive for anterior thigh pain. MRI was reviewed. Diagnosis was L4 and/or L5 radiculopathy from the left-sided intraforaminal disc herniation at L4-L5. It was noted that the patient's symptoms had progressed over the next couple days. recommended two sessions of therapy including McKenzie exercises per week for four weeks.

From September 20, 2013, through October 25, 2013, the patient attended six sessions of therapy consisting of therapeutic exercises, icepack, therapeutic activities and manual therapy.

On September 24, 2013, evaluated the patient for left leg pain. The patient had pain in the lateral thigh and lateral leg. Sometimes she had discomfort in the anterior thigh and anterior leg as well as posterior thigh and posterior leg. She had decreased strength in the left leg. History was positive for ablation and torn left rotator cuff. On examination, she had hypoactive reflexes of both knee jerks and ankle jerks. Sensory testing was unremarkable with flexion and extension but it caused some leg pain with flexion. reviewed the MRI of the lumbar spine and assessed left lumbar radiculopathy with equivocal evidence of nerve root compression and herniation. He recommended an epidural steroid injection (ESI) due to the radicular symptoms. He also recommended obtaining an electromyography (EMG) for her subjective weakness. The patient was to follow-up for rehab. If she was no better with those issues, then she was to see.

Per utilization review dated October 4, 2013, the request for ESI at L4-L5 was denied with the following rationale: *"For the described medical situation, medical necessity for this specific request would not be supported per criteria set forth by the above noted reference. The above noted reference would not support this*

specific request to be one of medical necessity as there is no documentation of radicular signs on physical examination, and a lumbar MRI obtained in the recent past did not reveal the presence of a focal compressive lesion upon a neural element in the lumbar spine. As a result, presently, medical necessity for this request is not established for the described medical situation. Peer to peer discussion was unsuccessful.”

On October 10, 2013, evaluated the patient for low back, hip and leg pain. The patient underwent EMG/nerve conduction velocity (NCV) study which showed no electrodiagnostic evidence suggestive of an acute lumbar radiculopathy, mononeuropathy or peripheral neuropathy. However, the patient’s symptoms might correlate with a radiculitis given discogenic pattern and finding on recent MRI. She might benefit from a diagnostic nerve block (L4 versus L5).

On October 28, 2013, rendered the following opinions: The objective signs of radiculopathy were not a requirement. The note documented symptoms in the anterior thigh and knee, which were consistent with an L4 pattern. As for the MRI scan, there was a disc herniation. It was agreed that that there was no nerve root compression, but the disc touched the nerve root and felt that a chemical radiculitis could occur from this herniation. Chemical radiculitis was a subject that was not covered by the ODG. He, therefore, submitted a request for a transforaminal ESI which could neutralize the chemical effect of the disc herniation in a situation not directly covered by the ODG.

Per reconsideration review dated November 4, 2013, the request for lumbar ESI was denied with the following rationale: *“Recommend adverse determination. It would be helpful to actually read ODG to see what it states. In fact, there do have to be examination findings of lumbar radiculopathy that must be corroborated by imaging and or EDS. In this case, MRI ruled out a neurocompressive lesion and EMG ruled out lumbar radiculopathy. ODG criteria #1 is NOT met. ALESI is NOT supported by ODG. Peer to peer contact was not successful.”*

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

According to the ODG, ESI(epidural steroid injections) are recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. The purpose of ESI is to reduce pain and inflammation, thereby, facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery.

Criteria for the use of Epidural steroid injections, per the ODG,

1. Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
2. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

3. Injections should be performed using fluoroscopy and injection of contrast for guidance.

The patient has met the criteria for radiculopathy as physical exam has demonstrated pain in the left lower extremity in a dermatomal distribution with demonstrated motor deficit in the same distribution. The radiculopathy is corroborated by MRI findings which demonstrated a disc protrusion into the neural foramen at the L45 level which is consistent with the physical exam findings. The patient has been unresponsive to conservative treatment as defined by the ODG. Thus, medical documentation does support the medical necessity of a L45 ESI.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES