

Parker Healthcare Management Organization, Inc.

3719 N. Beltline Rd Irving, TX 75038

972.906.0603 972.906.0615 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 6, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed second right Lumbar ESI at L5-S1 Epidurography, appeal with fluoroscopy and recovery

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 Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

REVIEW OUTCOME

PATIENT CLINICAL HISTORY [SUMMARY]:

CLINICAL HISTORY:

The injured employee is a male who reported a work-related injury, which occurred on xx/xx/xx. The injured employee reported the onset of back pain.

The injured employee was evaluated at xxxxx on xx/xx/xx. A sharp pain in the center of the low back was reported. The pain was rated at 8/10 in intensity and did not radiate. The pain was worse with extension from a flexed position. The physical examination was incomplete; the treatment plan was not provided for review.

The injured employee was re-evaluated on March 18, 2013. It was noted that the pattern of symptoms was improving and the injured employee felt better. The pain was rated at 4/10 in intensity. The pain was noted to be worse with bending. The physical examination documented equal reflexes and intact sensation. Motor strength was normal and straight leg raise was negative. There was no palpable spasm or signs of external trauma of the lower back. No point tenderness was noted. Full range of motion was documented. The assessments made were lumbar strain and lumbar pain. Work restrictions were provided and previously prescribed medications were continued. This was continued on March 22, 2013. On March 28, 2013, the injured employee reported feeling much better. It was noted that the injured employee was not taking pain medications and the condition was improved. The physical examination documented mild tenderness to palpation localized at the right side of the lower lumbar region. Gait was normal and there was full range of motion of the back. The assessments made were lumbar strain and back pain. The injured employee was released from care at maximum medical improvement without evidence of permanent impairment.

A lumbar spine MRI was performed on August 19, 2013. The study documented:

1. At the L5-S1 level, there was a focal right subarticular disk protrusion measuring 4mm in anteroposterior extent. This compressed the right S1 nerve root. The central canal at L5-S1 was mildly narrowed. There was also mild disc narrowing, and desiccation,
2. At the L4-L5 level, there was mild disc dehydration, and a 1-2mm generalized disc bulging. There was no significant central canal, or foraminal stenosis, and
3. The upper lumbar levels were within normal limits.

The injured employee was re-evaluated at on September 16, 2013. Continued pain with activity was noted. Numbness and tingling down the posterior right leg to the outer calf was reported. The physical examination documented tender paraspinal muscles in the lower lumbar spine without spasm. Straight leg raise was positive on the right. The sciatic notch was tender on the right. There was no spinous process tenderness. Reflexes were symmetric. Decreased range of motion in all planes was noted. Sensation was normal. The diagnoses made were lumbar radiculopathy and lumbar strain. Work restrictions were provided. Cyclobenzaprine 5mg, one tablet twice daily, and meloxicam 15mg, one tablet daily, were prescribed. Hydrocodone 10mg was continued. An orthopedic spine referral was made.

The injured employee was evaluated by M.D., on September 18, 2013. A history of facet injections and three sessions of physical therapy was reported. The physical examination documented no obvious muscle spasm or deformity. Moderately limited range of motion was noted. Straight leg raise was noted to cause pain on the right. A blunted Achilles reflex was noted in the right lower extremity. Motor strength was normal. Patellar reflexes were symmetrical. The recent lumbar spine MRI was reviewed. The diagnosis made was right S1 radiculopathy secondary to a chronic posterolateral disc herniation on the right at L5-S1. Lumbar epidural steroid injections were recommended.

performed a lumbar epidural steroid injection at the L5-S1 level on October 10, 2013. No complications were reported. Upon re-evaluation on October 17, 2013, a 60% to 70% decrease in symptoms was noted. A second lumbar epidural steroid injection was recommended and physical therapy was ordered. Work restrictions were provided. A previous prescription for tramadol was continued. A second lumbar epidural steroid injection was again recommended on November 5, 2013.

A Peer Review was completed on November 11, 2013. It was determined that a second lumbar epidural steroid injection was not appropriate.

re-evaluated the injured employee on November 19, 2013. Continued improvement was noted. It was noted that the previous request for a second lumbar epidural steroid injection had been denied. It was noted the injured employee had not been in physical therapy and continued an active exercise program on his own.

A Peer Review was completed on December 3, 2013. It was noted that an appeal request for a second right lumbar epidural steroid injection at L5-S1 was not appropriate, as the guideline recommendation of 50% to 70% pain relief lasting six to eight weeks after the first injection was not met. It was also noted that no examination findings consistent with persistent objective signs of radiculopathy were noted.

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.

As noted in the Division-mandated Official Disability Guidelines, repeat epidural steroid injections of the lumbar spine are recommended when 50% to 70% lasting six to eight weeks is documented after the original injection.¹ It was noted that the request for the second injection was made approximately seven days after the first injection and continued relief lasting six to eight weeks was not documented. No physical examination findings documenting signs of continued radiculopathy were noted after the initial evaluation on September 18, 2013, or after the initial epidural steroid injection of October 10, 2013. No additional records documenting continued relief after the initial injection were provided for review. Based on these factors, the request for a second lumbar epidural steroid injection at L5-S1 with epidurography, fluoroscopy, and recovery is not supported. The previous denial is upheld.

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

¹ Official Disability Guidelines Low Back (updated 12/27/13)