

Maturus Software Technologies Corporation

DBA Matutech, Inc

881 Rock Street
New Braunfels, TX 78130
Phone: 800-929-9078
Fax: 800-570-9544

Notice of Independent Review Decision

October 15, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L4-L5 and L5-S1 facet joint injections

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:

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

ODG criteria has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury to her back and left arm on xx/xx/xx. She slipped on ice and fell backwards. She hit her low back area and left wrist.

On December 10, 2013, evaluated the patient for left wrist and low back pain rated at 3/10 with activity. She took over-the-counter (OTC) Aleve which did not help. The patient felt she was able to perform regular job duties. Past medical history was positive for asthma and migraine headaches while surgical history was positive for left ring finger surgery. Lumbar examination revealed tenderness with palpation at spinous process, sacrum and coccyx area and paraspinous area. There was pain with side-bending and rotation. Left wrist examination revealed tenderness at the radial aspect and pain with adduction and abduction. X-rays of the left wrist were negative. X-rays of the lumbar spine with sacrum and coccyx

were negative for fracture. diagnosed contusion of the lumbar region, contusion of sacrum and coccyx and wrist contusion; prescribed Mobic; provided point relief for local application and large ice pack; and recommended regular activity at work.

On December 12, 2013, noted the patient continued to have pain in the lower back that was constant and worse with lifting and twisting. A day ago, she was lifting a package and turned to put it on the belt when felt sharp pain in the tail bone. The pain went away fast and again she had the same pain. The patient still had pain in the left wrist with movement only. Left wrist examination revealed mild tenderness at the radial aspect and full range of motion (ROM) with pain with radial deviation and flexion. Lumbar examination showed tenderness of the paraspinal muscles, at the sacrum and coccyx and painful ROM with extension and side bending. X-rays revealed degenerative changes of the lumbar spine and the wrist. diagnosed contusion of the lumbar region, contusion of sacrum and coccyx and wrist contusion; gave a wrist brace; continued medications and instructed the patient on no lifting over 20 lbs.

On December 18, 2013 and December 26, 2013, there were documented sessions of physical therapy (PT) with the modalities consisting of therapeutic exercises, therapeutic activities, manual therapy and electrical stimulation.

On December 19, 2013, noted the patient still reported pain in her tailbone with heavy feeling in the lower back. The patient sometimes felt numbness of the lower back. She also had pain in the left wrist radiating to the forearm. She was using a brace and Mobic and was working light duty. Examination of the left wrist showed mild tenderness of the radial aspect, pain with radial deviation and decreased and painful flexion. Examination of the lumbar spine revealed tenderness at the paraspinal muscle at the sacrum and coccyx. Treatment was continued with therapy, wrist brace and Mobic.

On December 26, 2013, noted the patient was able to work modified duty. She had noted improvement with two sessions of PT. Current pain was rated as 3/10 with activity. On examination, there was tenderness and spasm in the paravertebral muscles and decreased and painful ROM in all planes. Left wrist examination showed tenderness in the dorsal and volar regions with pain with ROM in all planes. Grip strength was decreased as well. The patient was restricted on lifting more than 10 pounds and was instructed to wear wrist brace.

On January 2, 2014, the patient returned for follow up for back, coccyx and left wrist pain, rated as 5/10. She had completed six sessions of PT. requested more PT.

On January 10, 2014, diagnosed sacral sprain, requested approval for additional PT and continued wrist splint, Mobic and modified activity.

On January 17, 2014, the patient reported persistent pain in the lower back that radiated down to the mid back. Left wrist pain radiated to the forearm and hand.

recommended starting PT once approved and continuing work restrictions and medications.

On January 20, 2014, evaluated the patient for low back pain radiating to the legs. The patient had attended 12 PT sessions. The prescription was provided for Celebrex and Flexeril. The handwritten record is illegible.

On January 24, 2014, evaluated the patient for the pain in the sacrum and low back area and constant wrist pain with movement, rated 3/10. The patient was wearing a splint. reported the patient had restarted PT since additional sessions were approved. Examination of the lumbar spine revealed tenderness in the sacral area on palpation and paravertebral muscle spasm in the lumbar area. There was decreased range of motion (ROM) and pain with flexion and extension of the left wrist. There was tenderness to palpation on the radial and mid portion aspect and decreased ROM with extension. diagnosed contusion of the lumbar region, sacrum, coccyx, and wrist, sacral sprain and wrist sprain. advised the patient to continue medications and PT and to wear a wrist brace.

On January 28, 2014, evaluated the patient for the intermittent low back and left wrist pain, rated as 3/10. He diagnosed contusion of the lumbar region, sacrum, coccyx, and wrist, sacral sprain and wrist sprain and prescribed Motrin, Celebrex and Flexeril.

On February 4, 2014, saw the patient for constant pain in the back and the left wrist. Examination of the wrist revealed moderate tenderness with mild muscle spasm and restricted ROM. referred the patient for wrist PT.

On February 7, 2014, the patient underwent PT initial evaluation. The evaluator recommended two to three therapies for three weeks with modalities to include manual therapy and therapeutic exercise.

On February 10, 2014, saw the patient for the pain in the lower back and left wrist. Examination of the lower back revealed tenderness of the spinous process, sacrum, coccyx area and paraspinal muscles on palpation. There was pain on side bending and rotation. X-rays of the left wrist and the lumbar spine showed no fractures. diagnosed contusion of the lumbar region, sacrum, coccyx and wrist, and prescribed Mobic. The patient was advised to apply ice to the affected area.

On February 12, 2014, evaluated the patient. Examination of the wrist revealed tenderness along the dorsal and radial aspects of the radiocarpal joint and in the areas of the capitulate joint and crepitus. noted the diagnostic lidocaine injection into the radial scaphoid joint was helpful. He administered betamethasone injection to the left radiocarpal joint and recommended outpatient occupational therapy (OT) for hand evaluation and x-ray of wrist.

On February 13, 2014, x-rays of the right and left wrist showed: (1) No acute osseous abnormality, (2) Generalized osteopenia, (3) Mild degenerative change of the bilateral radiocarpal and bilateral first carpometacarpal (CMC) joint.

On February 18, 2014, noted the lidocaine injection showed improvement. Examination showed mild tenderness to the back and wrist with restricted ROM. He prescribed Celebrex and Flexeril and referred the patient to the orthopedic surgeon.

On February 19, 2014, the patient underwent PT initial evaluation. The evaluator recommended OT two times a week for four weeks with modalities to include manual therapy, therapeutic exercise and ultrasound through March 26, 2014.

On March 4, 2014, noted complaints of cramps in the left leg, back pain radiating to the tailbone and persistent pain in the wrist with splint. Celebrex and Flexeril were continued and the patient was referred to an orthopedic surgeon.

On March 6, 2014, magnetic resonance imaging (MRI) of the lumbar spine without contrast revealed mild narrowing and dehydration in the L4-L5 disc with a 2.4 mm central disc protrusion compressing the thecal sac and produced canal narrowing; there was dehydration with narrowing and slight disc bulge or spur at L5-S1 with canal narrowing; there was right foraminal narrowing at L4-L5 and bilateral facet arthropathy at L4-L5 and L5-S1.

On March 13, 2014, noted intermittent pain in the lower back and wrist. Examination revealed tenderness and limited ROM. diagnosed contusion of the lumbar region, sacrum, coccyx and wrist, sacral sprain and wrist sprain and advised the patient to use splint at work.

Per a progress note dated March 17, 2014, the patient had slight improvement with activity tolerance and strength measures. She was recommended to continue with occupational therapy two times a week for four weeks. The patient was informed to get authorization for MRI and this was to be scheduled.

On March 19, 2014, evaluated the patient for low back and buttock pain and heavy feeling in the tailbone and across the low back. The patient still had some numbness or heavy feeling to her buttocks bilaterally. Celebrex and Flexeril made her sleepy and were not helpful. The patient had attended 10 sessions of PT which were also not helpful. Sitting on a pillow helped the pain in the tailbone. The pain would awaken her from sleep and it was relieved by resting legs and bending forward and worsened with rising from chair, lying down and physical activity. She was utilizing Imitrex and Zantac. On examination, there was tenderness to palpation of the lumbar spine at L4-L5, tenderness to the lumbar paravertebral musculature bilaterally and muscle spasms. There was pain to palpation at the bilateral sacroiliac (SI) joint. Straight leg raise (SLR) was negative bilaterally. Right extensor hallucis longus (EHL) strength was 4-5/5. There was pain with lumbar extension and lateral bending. obtained x-rays of the lumbar spine and on AP views noted slight bit of rotation and curve to the left,

decreased joint space at the hips bilaterally and slightly higher iliac crest on the right side as well as at the hips. On lateral views, he noted disc space narrowing at L5-S1 and to a lesser degree at L4-L5 and possible facet arthrosis at L5-S1. MRI of the lumbar spine was reviewed. He diagnosed loss of disc signal/narrowing at L5-S1 and L4-L5, L4-L5 disc bulge and lumbar radiculopathy. He felt the patient had spondylolisthesis at L4-L5 and stenosis and hypertrophy at L5-S1. He felt these were largely degenerative problems and it was certainly possible that these were flared up by the fall. He stated he would not state that they were definitely caused by the fall. He recommended conservative treatment with continuing therapy and epidural steroid injection (ESI) at the L5-S1 level. Imitrex and Zantac were continued.

On March 20, 2014, MRI of the left wrist revealed marked cartilage loss in the radiocarpal compartment with degenerative arthritic changes. There was moderate marrow edema and small subchondral cysts in the lunate. There was scaphoid and mild marrow edema in the proximal capitate which might all be due to arthritic disease, but superimposed marrow contusions might not be excluded. No fracture noted. There was no widening of the scapholunate space, but a mild dorsal tilt of the lunate. There were small subchondral cysts or erosions subjacent to the fovea of the distal ulna with mild surrounding marrow edema. The intrasubstance signal on the radial and ulnar sides of the TFCC were compatible with degeneration and/or intrasubstance tear. No defect in the TFCC was evident. There was severe degenerative arthritis in the first carpal-metacarpal joint. There was small distal radioulnar joint effusion.

On March 25, 2014, noted the patient had no change in her symptoms and returned to review the MRI. He reviewed the MRI and noted a definitive scapholunate ligament injury was not seen, but was suspected. There was evidence of significant degeneration in the wrist, capitolunate joint and radiocarpal joint. He did not feel that the primary repair of the scapholunate ligament or even a reconstruction such as a Brunelli procedure would provide long-term relief. He also opined that most likely, the patient needed a scaphoid excision and 4 corner fusion to provide adequate long-term pain relief. The patient wanted to continue therapy and conservative treatment before deciding to do surgery. The patient was recommended to continue therapy and return in a month.

Per a progress note dated March 26, 2014, the patient reported no improvement in pain, limited improvement with strength and mild improvement with ROM. She had increased use with ADLs. She was recommended continued therapy two times a week for four weeks.

On March 27, 2014, saw the patient for ongoing symptoms of left wrist pain and low back pain. She rated the pain at 2-3/10 in the back and wrist. The patient noted she had visits with specialists and PT was ordered for the hand. Surgery was being considered. Steroid injections were ordered for her back. The handwritten notes are illegible.

Per a peer-to-peer call dated April 2, 2014, noted that the left side ESI at L5-S1 was geared, but she had some right-sided EHL weakness. He reported of some confusion as far as doing ESI in the left side. Ms. informed him that the side was probably chosen as it was more painful. She suggested that it could get to either side in regards to where the medications went. The question of radiculopathy was answered as positive since the patient had bilateral buttock pain. stated that he would still consider the injection and leave off left right side since the patient had EHL weakness.

On April 10, 2014, evaluated the patient for low back pain and left wrist pain. The patient was utilizing Celebrex and Flexeril. She rated her pain at 3/10. She needed more Flexeril. recommended continuing medications and recommended follow up with the orthopedist. The handwritten notes are illegible.

From April 11, 2014, through May 13, 2014, the patient underwent OT with modalities to include therapeutic exercises and manual therapy.

On April 17, 2014, saw the patient for recheck of left wrist. She was attending therapy twice a week and still had pain. She was working light duty with restrictions of no lifting over 20 pounds. She still had limitations with activity and motion. recommended proceeding with a scaphoid excision and 4-corner fusion if her condition failed to improve.

On April 22, 2014, noted the patient felt her back was so bad that she felt she was going to pass out. She rated her pain at 3/10 in the low back. She was utilizing Celebrex and Flexeril and was undergoing therapy. She reported that she was under the care and might undergo surgery or get injection if approved by her insurance. The patient was recommended to follow up. The handwritten notes are illegible.

On May 6, 2014, PA-C, noted that had not yet decided on whether or not surgery was needed, for the patient. The patient continued with ongoing symptoms. The patient was to continue medication regimen. No medications were provided. The handwritten notes are illegible.

On May 15, 2014, noted the patient did not have good ROM and was starting to get new pain on the back of the hand and left thumb. She was discharged from therapy and was wearing a brace only when picking up something heavy. She was not working. recommended scaphoid excision surgery for the left wrist and consultation or care plan of her left wrist.

On May 21, 2014, noted complaints of back and leg pain located on the both sides. Now the pain radiated intermittently down the posterior thigh and calf. Somewhere in April, the patient began having bilateral posterior thigh and calf pain. Over the last couple of weeks, she started having some foot pain bilaterally. On examination, there was tenderness in the lumbar spine, paravertebral musculature with muscle spasms bilaterally. Right and left EHL strength was 4-5/5. Flexion and extension of the lumbar spine caused pain. felt disc herniation

at L5-S1 corresponded with back and bilateral posterior thigh and calf pain. He appealed for an ESI at L5-S1 and recommended follow up after the injection.

On June 6, 2014, noted the patient's wrist surgery was not approved and was appealing the decision. The patient stated was also appealing for denial of additional back mechanics. The patient rated pain at 3/10 in the back and left wrist. No medications were prescribed. The handwritten notes are illegible.

On July 7, 2014, noted the patient had tingling and numbness in the right leg. She had weakness in her low back radiating to the right leg. The patient rated her pain at 5/10 in the low back. She reported that she would get pains up and across her back with turning. She had got steroid injections approved. She was still working on getting her surgery approved for the left wrist. recommended follow up.

On July 16, 2014, performed a left intralaminar ESI at L5-S1.

Per a Medical Cost Projection (MCP) report dated August 5, 2014, the patient's adjusted life expectancy, based upon the rated age, was 21.4 years. The total estimated cost of treatment was \$1,463.24 annually with an estimated LE cost being \$31,313.33. The category included physician visits, outpatient surgery procedures, hospitalizations, nursing care, therapeutic modalities, pharmacy/medications, transportation, case management, diagnostic/lab work, cost containment fees, DME/supplies and miscellaneous expenses.

On August 7, 2014, saw the patient regarding sprain/strain of the left wrist and back. The patient had an ESI in the back. She rated her pain at 3-5/10. She reported that the injection helped her legs for a while, but the pain returned. It never helped her back. She also reported that she was scheduled for surgery on the left wrist the next day. She was to see on August 12, 2014. recommended proceeding with the left wrist surgery.

On August 8, 2014, performed left wrist scaphoid excision with 4-corner fusion.

On August 12, 2014, evaluated the patient for ongoing issues of congenital spondylolisthesis, lumbosacral neuritis or radiculitis unspecified and lumbar intervertebral disc without myelopathy. The patient felt better since the last visit. She was able to walk and balance on heels and toes. There was tenderness to palpation on the lumbar spinous processes at L4-S1. There was tenderness in the lumbar paravertebral musculature bilaterally as well as muscle spasm. She had tight hamstrings bilaterally. She had 4-5/5 strength in the EHL and tibialis anterior bilaterally, otherwise 5/5 in other muscles. There was painful ROM of the lumbar spine. The patient did not get any better at the back. recommended injection at the facets to address the back pain that could be coming from the L4-L5 instability which flared up by the injury. She also diagnosed disc herniation at L5-S1, lumbar radiculopathy and facet arthropathy and recommended facet injection to the L4-L5 and L5-S1 bilaterally.

From August 18, 2014, through September 11, 2014, the patient underwent OT with modalities to include therapeutic exercises, manual therapy and application of paraffin to the hand.

Per utilization review dated August 26, 2014, the request for bilateral L4-L5 and L5-S1 facet joint injection was denied with the following rationale: *“ODG does not recommend facet injection when a radiculopathy is present. This patient has recurrent document complaints with evidence of tibialis anterior and EHL weakness that responded positively to the ESI, reducing the patient's leg symptoms. The requested bilateral L4-L5 and L5-S1 facet injection is not medically necessary.”*

On September 10, 2014, evaluated the patient for left wrist and back pain. The patient rated the pain at 3/10 in the back. The pain was constant and worse with lying, standing, sitting, walking, twisting, bending, climbing and reaching. She had weakness in the low back radiating down her bilateral legs. She had surgery on the left wrist and was undergoing therapy twice a week. She had restricted ROM. The scar was well-healed. She was waiting for approval of her second injection. recommended continuing therapy.

Per reconsideration review dated September 12, 2014, the appeal for bilateral L4-L5 and L5-S1 facet joint injection was denied with the following rationale: *“The guidelines do not support facet joint injections in cases where there is radiculopathy. ODG-TWC Low Back Procedure Summary lists criteria for use of therapeutic intra-articular and medial branch blocks. In this case, it is noted that the claimant continues to report back pain, despite improvement in leg symptoms after a left-sided epidural steroid injection at L4-L5. The established medical guidelines note that there should be no evidence of radicular pain. Therefore, the claimant does not meet the inclusion criteria due to documented weakness in the anterior tibialis muscles and improvement with the ESI. The medical necessity of this request is not established.”*

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

ODG-TWC Low Back Procedure Summary lists criteria for use of therapeutic intra-articular and medial branch blocks. In this case, it is noted that the claimant continues to report back pain, thus facet injection is medically necessary (using the medial branch block technique not intra-articular technique).

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES