

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

Notice of Independent Review Decision

August 19, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection (ESI)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. He felt pain in the low back and it was hard to move after that.

On xx/xx/xx, evaluated the patient for low back pain. The pain level was 7/10 and it was described as sharp and shooting. Examination of the lumbar spine showed extension of 90 degrees with pain and pain on side rotation bilaterally. There was spasm of both paraspinal muscles at the level of L3, L4 and L5. diagnosed lumbar strain and back strain, prescribed Naprosyn, cyclobenzaprine, Biofreeze and gel icepack and recommended starting physical therapy (PT). The patient was to remain off work. He might return to work for the following scheduled shift with restrictions.

On October 7, 2013, the patient felt the pattern of his symptoms was slowly improving. He had not been working, as no light duty was available. He was taking medication; some relief symptoms were noted. He underwent PT and was making progress. recommended continuing medications and completing PT.

On October 15, 2013, evaluated the patient for ongoing low back pain. The patient was making slow progress and still had pain in his low back at 4/10. The patient was tolerating medications and they helped. refilled naproxen and added Flexeril. The patient was to continue his previous therapy schedule.

On October 22, 2013, noted the patient had some difficulty with selected job functions. He had been taking his medications and had noted some improvement of symptoms. He underwent PT and felt a slight improvement in his functional status. recommended continuing the previous medications and referred the patient for six additional sessions of PT.

On October 31, 2013, instructed taking over-the-counter (OTC) Aleve and completing PT.

On November 14, 2013, the patient reported that he could not work, as his pain was worse when he would work and could not lift heavy things. The low back pain radiated to the left leg and his left leg would go numb on occasions. He had persistent symptoms despite conservative treatment. ordered a magnetic resonance imaging (MRI) of the lumbar spine. The patient was to complete PT and was to take OTC Aleve as instructed.

An MRI of the lumbar spine dated November 21, 2013, showed a broad 1-mm disc protrusion at L4-L5 with a 2.5-mm central component causing mild thecal sac stenosis and a broad 1-mm disc bulge at L5-S1.

On November 25, 2013, reviewed the MRI findings and diagnosed lumbar radiculopathy, lumbar strain and herniated disc at L4-L5. The patient was referred to physiatrist for possible injections. A prescription for tramadol was provided and he was instructed on home exercise program (HEP).

On December 27, 2013, evaluated the patient for ongoing low back pain. The patient told that he recently was out of work for one week because the cold weather made his pain worse and there was no light duty available when working out in the field. diagnosed lumbar strain, lumbar radiculopathy, lumbar intervertebral disc displacement and overexertion from sudden strenuous movement. He prescribed Ultram and rescheduled appointment.

On February 5, 2014, performed a designated doctor evaluation (DDE) and rendered the following opinions: The patient had not achieved maximum medical improvement (MMI) and therefore an impairment rating (IR) had not been assigned. MMI was estimated on April 5, 2014, with the patient participating in a formal work conditioning or multi-disciplinary program. On functional capacity evaluation (FCE), the patient did not meet his reported job lifting requirements of

>100 lbs. He was self-limiting with dynamic lifting due to complaints of low back discomfort. The patient was currently able to work at a modified "Medium" duty status. It was unclear if the restricted level of duty was available for the patient. He certainly would not be able to function as a roofer nor as a roofer's helper. He would be off work for a multi-disciplinary program.

noted on February 25, 2012, that the patient had been seen who had released the patient to regular duty. referred the patient for a work-conditioning program (WCP).

On March 11, 2014, recommended 9 sessions of WCP.

On April 2, 2014, noted the pattern of symptoms was improving. The patient felt better. He was instructed on an HEP.

On May 28, 2014, evaluated the patient for low back pain. The patient had attended PT and a partial WCP. He had a constant pain about 6/10. Examination of the low back revealed mild lumbar tenderness bilaterally. He had good range of motion (ROM). diagnosed lumbar strain with chronic low back pain, prescribed hydrocodone-acetaminophen and meloxicam and referred the patient to an FCE for work restrictions and activity recommendations. A possible work hardening program (WHP) was to be considered.

On June 16, 2014, evaluated the patient for moderate-to-severe low back pain and limited ROM and radiating pain into both the lower extremities. The pain level was at 6-7/10. On examination, there was moderately restricted ROM by 20% in lumbar flexion, extension and lateral bending with pain. There was hypoesthesia to light touch and pinprick in the L5 distribution bilaterally. The deep tendon reflexes (DTR) were diminished at both knees. The patient could heel and toe walk with difficulty, SLR was positive bilaterally at 75 degrees. There was bilateral sciatic notch tenderness. reviewed the MRI findings that showed a 4-mm posterior central disc protrusion at L4-L5 which mildly impinged upon the thecal sac and both the L5 nerve roots. The protrusion moderately narrowed both the lateral recesses. There was a 2-mm posterior central disc protrusion at L5-S1 which extended into the epidural fat without contacting the thecal sac or the neural elements. recommended proceeding with a lumbar epidural steroid injection (ESI) at L4-L5. The radicular component was confirmed by physical examination and previous MRI study.

Per a utilization review dated June 24, 2014, the request for lumbar ESI was denied with the following rationale: *"The patient is a male who was on xx/xx/xx. He has received treatment in the form of medications, work restrictions, rest, HEP and PT from xx/xx/xx, to November 13, 2013, and a Work Conditioning program. A lumbar MRI on November 21, 2013, showed a disc protrusion at L4-L5 with thecal sac stenosis and a disc bulge at L5-S1. He presented on May 28, 2014, with low back pain graded 6/10 on VAS. He was on hydrocodone-acetaminophen and meloxicam. Lumbar findings included good ROM, bilateral tenderness, full strength, intact sensation and negative straight leg raise test. The level and*

laterality of the requested LESI were not specified. The clinical findings of intact sensation and negative straight leg raise are not suggestive of lumbar radiculopathy. Electrodiagnostic or radiologic evidence of nerve root pathology was not seen. Based on the examination and diagnostic findings, the medical necessity of a LESI cannot be validated at this time."

Per a reconsideration review dated July 15, 2014, the request for appeal of lumbar ESI was denied with the following rationale: *"The patient is a male who sustained an injury on xx/xx/xx (as per report dated May 28, 2014). He is currently diagnosed with lumbar strain with chronic low back pain. An appeal request for a lumbar ESI is made. The previous request was non-certified on June 24, 2014, based on the grounds that the level and laterality of the requested lumbar ESI were not specified; that the clinical findings of intact sensation and negative straight leg raise are not suggestive of lumbar radiculopathy; and that electrodiagnostic or radiologic evidence of nerve root pathology was not seen. Updated documentation submitted for review includes the medical reports/treatment notes from October 7, 2013, to April 2, 2014. From xx/xx/xx, to November 13, 2013, the patient has had treatment with PT. The lumbar MRI study dated November 21, 2013, showed a broad 1-mm disc protrusion at L4-L5 with a 2.5-mm central component causing mild thecal sac stenosis; and a broad 1-mm disc bulge at L5-S1. The history and physical report dated May 28, 2014, states that the patient has constant pain rated 6/10. He takes an occasional hydrocodone for this. He is not working. In the past, he had PT and partial Work Conditioning. Medications at this time include hydrocodone-acetaminophen and meloxicam. Physical examination of the lumbar spine revealed mild tenderness bilaterally. There was good range of motion and the SLR test was negative. Motor strength, sensation and reflexes were all within normal limits. His one leg stance and toe and heel stance were normal. In the June 16, 2014, evaluation, the patient complained of moderate-to-severe lower back pain, limited range of motion and radiating pain into both the lower extremities. He rated his pain at 6-7/10. Physical examination revealed moderately restricted lumbar range of motion with pain. There was hypoesthesia in the bilateral L5 distribution. The deep tendon reflex was diminished at both knees. The patient can heel and toe walk with difficulty. The SLR test was positive bilaterally at 75 degrees. There was bilateral sciatic notch tenderness. The provider stated that on review of the MRI study dated November 21, 2013, there was a 4-mm posterior central disc protrusion at L4-L5, which mildly impinges upon the thecal sac and both the L5 nerve roots. The protrusion moderately narrows both the lateral recesses. There was also a 2-mm posterior central disc protrusion at L5-S1 which extends into the epidural fat, without contacting the thecal sac or the neural elements. A lumbar ESI at L4-L5 was requested. Treatments rendered to date include medications, work/activity restrictions, PT, WC (ten sessions), and HEP. The report dated June 16, 2014, states that the requested ESI will be administered at L4-L5. It is noted that the patient has been evaluated by two different providers on May 28, 2014, and June 16, 2014. The evaluation performed on May 28, 2014, revealed findings that were not suggestive of lumbar radiculopathy. The evaluation on June 16, 2014, on the other hand, showed findings that are consistent with radiculopathy at the requested level. The provider on the visit June 16, 2014, also stated that the*

lumbar MRI dated November 21, 2013, showed mild impingement of the bilateral L5 nerve roots but this was not noted in the radiologist's report. Clarification may be needed as to actual lumbar physical examination findings of the patient as well as the findings of the lumbar MRI study if they are consistent with radiculopathy or not. As there is discrepancy in the objective findings reported, the medical necessity of the requested lumbar ESI remains to be not established in agreement with the previous determination."

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

Per ODG, patient has findings of lumbar disc injury at L45 with radicular signs and symptoms. An ESI is appropriate.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES