

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

Notice of Independent Review Decision

March 16, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5-S1 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:

Upheld (Agree)

Medical documentation **does not support** 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 (65 inches tall, 136 pounds and body mass index of 22.71) who sustained an injury on xx/xx/xx. The patient was stepping off a platform and fell and hit his back against a bar.

Prior treatments included medications (Duexis, Tylenol with Codeine, prednisone, ibuprofen, Soma, Zanaflex and Celebrex), physical therapy (PT) and a lumbar ESI on December 23, 2014.

Computerized tomography (CT) scan of the lumbar spine dated September 26, 2014, documented bulge of the disc at L5- S1 with question of minimal protrusion of the disc material. There was bulge of the disc at L4-L5 and straightening of the normal lordotic curve. No fracture was seen.

evaluated the patient on October 7, 2014, for low back pain radiating down both legs. The pain caused him to wake up from sleep. Standing and walking for long periods caused pain. Examination demonstrated significant paraspinal tenderness, positive straight leg raising (SLR) bilaterally and poor range of motion (ROM) with flexion, extension, side bending and rotation. x-rays in the office showed no instability or fracture. Review of CT scan demonstrated disc herniation at L5-S1. Zanaflex and Celebrex were prescribed.

The patient underwent PT evaluation on October 15, 2014, followed by a session of therapy on November 25, 2014.

Magnetic resonance imaging (MRI) of the lumbar spine dated October 17, 2014, documented a central disc protrusion of 3 mm at L5-S1 with annular fissuring. There was no canal stenosis or evidence of neural impingement. There was no additional disc bulge, herniation or acquired canal stenosis. The neural foramina were patent at all levels. There was mild straightening of the lumbar lordotic curvature without fracture or listhesis.

reviewed the MRI findings on November 18, 2014, and placed the patient on Duexis. A neuromuscular stimulator was given and a lumbar epidural steroid injection (ESI) was recommended as the patient continued to have low back pain radiating to the legs.

According to the progress note dated November 25, 2014, the patient had seen minimal improvement in pain levels but this time were still significant and interfered with the daily activity level. The pain was rated at 7/10 currently, 5/10 at best and 9/10 at worst. The patient had moderate limitations in walking, recreational exercise, sitting and standing. On examination, active range of motion (ROM) of the lumbar spine showed flexion of 30 degrees, extension at 15 degrees, bilateral side bending at 20 degrees, and bilateral rotation at 45 degrees. The psoas strength was graded 4-/5. There was positive slump test, SLR test, quadrant test (lumbar spine) and neurotension test. There was sub-acute spasm of the lumbar spine paraspinals into the gluteal. There was extensive pain with all provocative testing. The myotomes were graded 4+/5 bilaterally. There was acute tenderness to palpation along the erector spinae and in the superior gluteal bilaterally. On assessment, the patient presented with elevated pain levels in the thoracolumbar spine with significant loss of functional ROM in normal movements.

The patient underwent a lumbar ESI at L5-S1 on December 23, 2014.

On January 8, 2015, the patient reported 40% relief of pain with the ESI, and would like to go ahead and pursue a second ESI. recommended Celebrex 200 mg to be taken 1 capsule orally times 2.

Per utilization review dated January 20, 2015, the request for a second lumbar ESI at L5-S1 was non-certified. Rationale: *"In this case, the patient had back and leg pain. There was disc bulge on MRI. The patient had ESI on December 23,*

2014, with just 40% pain relief for less than six weeks. Therefore, the request for a second lumbar ESI at L5-S1 was not medically necessary and appropriate.”

On February 4, 2015, the appeal for a second ESI at L5-S1 was denied with the following rationale: *“In this case, the patient has findings of lumbar radiculopathy, but only got 40% relief for 6-8 weeks. There was no EMGNCV study done to establish radiculopathy. MRI findings showed no nerve root impingement. Per ODG guidelines if after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than four blocks per region per year. Repeat injections should be based on continued objective documented pain relief decreased need for pain medications and functional response. Therefore, the request is outside the guidelines and is not medically necessary.”*

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

Per ODG the repeat epidural steroid injection did not produce adequate pain relief to qualify for a repeat injection.

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