

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 6, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Outpatient Lumbar Transforaminal ESI with fluoroscopy at L5-S1

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

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.10	Lumbar ESI		Prosp	1					Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee is a male who reported a work-related injury, which occurred on xx/xx/xx. The injured employee tripped and fell while carrying a 30-pound pole.

A lumbar spine MRI was performed on September 26, 2014. The impression was:

1. A broad-based posterior disc herniation measuring approximately 4 mm at L5-S1 with resulting mild-to-moderate bilateral foraminal stenosis but without central spinal canal stenosis and
2. A broad-based posterior disc herniation measuring approximately 3 mm at L4-L5 with minimal bilateral foraminal stenosis.

The injured employee was evaluated on October 29, 2014. It was noted that he had been under care since September 3, 2014, and was found to have disc herniations in his lower back upon MRI review. A decreased lumbar spine range of motion was noted upon

examination. Eighteen sessions of chiropractic treatment were recommended.

A preauthorization review was completed on November 24, 2014. A request for eighteen additional sessions of chiropractic treatment was not certified.

A neurologic evaluation for electrodiagnostic testing was completed on January 13, 2015, at. The impression was:

1. A needle EMG/NCV study of the bilateral lower extremities and related paraspinal muscles revealed neurophysiological evidence of a mild lumbosacral nerve root irritation/radiculitis at L5-S1 on the left,
2. There was no significant neurophysiological evidence of active demyelination noted. There was no neurophysiological evidence of peripheral neuropathy or myopathy. No neurophysiological evidence of peroneal neuropathy, posterior tibial neuropathy, sciatic neuropathy, or lumbosacral plexopathy on either side. Clinical correlation was warranted,
3. A lumbar disc protrusion/herniation, and
4. Low back pain and muscle spasms.

A preauthorization review was completed on January 26, 2015. A request for a lumbar brace was not certified.

He was evaluated on February 9, 2015. A complaint of low back pain was reported. It was noted that electrodiagnostic testing revealed evidence of nerve root irritation on the left at L5-S1. Evidence of numerous bulging discs in the lumbar spine was noted. Norco, and Robaxin were to be continued, and Relafen was prescribed. A lumbar epidural steroid injection was requested. The physical examination revealed normal spine curvature without deformity, ecchymosis, erythema, or lesions. There was lumbar midline and paralumbar tenderness. There was left buttock tenderness. Normal symmetry, tone, strength, and range of motion were noted. The assessments made were a lumbar disc displacement, lumbar neuritis/radiculitis, and a backache.

A preauthorization review was completed on February 12, 2015. A request for a transforaminal epidural steroid injection at L5-S1 was not certified due to a lack of corroborative subjective complaints or objective findings upon physical examination suggestive of a radiculopathy.

A letter of reconsideration was completed on February 20, 2015. It was noted that the injured employee had EMG evidence of nerve irritation at L5-S1 on the left, and a transforaminal injection was requested on that side at L5-S1. It was noted that the injured employee had physical examination evidence of significant pain on the left lower extremity in the same dermatomal distribution as the bulging disc.

re-evaluated the injured employee on March 9, 2015. A Designated Doctor Evaluation had been completed which determined that a radiculopathy was not present. felt that the electrodiagnostic testing did reveal evidence of a radiculopathy, and the injured employee presented with findings of radiculopathy and decreased range of motion, which had failed to respond to conservative treatment. The physical examination revealed no spine deformity. There was increased pain with palpation across the lower lumbar region on the left side greater than the right side. There was a limited range of motion of the lumbar spine. The Kemp's test was positive on the left. A positive straight leg raise test on the left was noted. The injured employee's gait was normal.

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/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division-mandated Official Disability Guidelines, lumbar epidural steroid injections are indicated when there is evidence of a radiculopathy upon physical examination, which is corroborated by findings on imaging studies and electrodiagnostic testing. The most recent physical examination documented a positive straight leg raise test; however, there was no documentation of a sensory disturbance, motor weakness, or asymmetric tendon reflexes consistent with a radiculopathy. No frank nerve root impingement was documented on the lumbar spine MRI of September 26, 2014, and the electrodiagnostic testing of January 13, 2015, indicated that findings were consistent with nerve root irritation/radiculitis, without findings of significant radiculopathy.

Based on these factors a request for a transforaminal epidural steroid injection on the left L5-S1 would not be indicated as medically necessity.

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

- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES