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Notice of Independent Review Decision

February 10, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L5 and S1 transforaminal epidural steroid injection, epidurography, fluoroscopy and sedation

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 female who sustained a job-related injury on xx/xx/xx. She experienced an intense pulling sensation in the back and her left shoulder area and within a few minutes, she was unable to move her left shoulder.

On July 9, 2013, a magnetic resonance imaging (MRI) of the lumbar spine was performed at Prime Diagnostic Imaging for low back pain with left lower extremity radiculopathy. The study revealed exaggerated lordosis of the lower lumbar spine centered at approximately L5. At L1-L2, L2-L3 and L3-L4, there was mild anterior endplate spurring with less than 1 mm anterior annular bulge. At L3-L5, there was mild anterior endplate spurring. The disc was slightly convex posteriorly. There was less than 1 mm anterior annular bulge. There was mild bilateral facet osteoarthritis and hypertrophy. L5-S1 revealed mild bilateral facet osteoarthritis

and hypertrophy. There was mild bilateral lateral recess/subarticular narrowing noted mainly due to the exaggerated lordosis of the lumbar spine. No compression fracture, spondylolisthesis or canal stenosis was seen at any lumbar level.

On August 21, 2013, electromyography/nerve conduction velocity (EMG/NCV) study of the bilateral lower extremities was normal. There was no electrophysiological evidence of lumbosacral radiculopathy, lumbosacral plexopathy, focal limb entrapment, mononeuropathy, generalized peripheral polyneuropathy, focal and/or generalized myopathy.

On August 21, 2013, evaluated the patient for low back pain and leg pain. The patient reported sharp pain in the lower back and all the way up to the left shoulder. The patient was diagnosed lumbar sprain and left acromioclavicular (AC) joint ligament sprain and spasm of the surrounding muscles. X-rays of the shoulder and lumbar spine were unremarkable. The MRI was reviewed. The patient noted the symptoms had slightly improved with treatment, but she still was symptomatic. The orthopedic surgeon had provided an opinion, but without seeing the patient. He felt the patient's injuries were soft tissue mainly. Apparently, the patient was undergoing some physical therapy (PT) and taking naproxen. Examination revealed brachioradialis, bilateral knee jerks and bilateral ankle jerks to be 1+ with flexor plantar responses. There was tenderness in the left sciatic notch and the posterior spinous processes associated with increased tone of the paravertebral muscles. An EMG/NCS was performed. diagnosed posttraumatic lumbosacral sprain/strain and pseudo sciatica secondary to L5-S1 facet osteoarthritis. He recommended continuing medications and PT. The need for a left L5-S1 facet steroid block was to be evaluated.

On February 3, 2014, performed a maximum medical improvement/impairment rating (MMI/IR) evaluation and stated the patient was not at MMI, but estimated to be on May 3, 2014. Additional information included: *"The patient had persistent symptoms after her injury and was worsening. She was taken to and was seen by. prescribed medications for pain control. The patient reported she had started a course of active rehab one week after the injury, but had no positive benefit. In fact, her pain got more severe. She then had an MRI of the left shoulder on July 9, 2013, that revealed a linear increase in signal within the inferior aspect of the infraspinatus which was interpreted as indicative of an underlying partial tear/grade II strain. A small glenohumeral joint effusion was also noted as well as mild left AC periarticular interstitial edema. She then saw on August 15, 2013, and was administered a corticosteroid injection to the left shoulder using a subacromial approach. The injection provided only one to two days of relief. Ultimately, the patient underwent arthroscopic extensive debridement of the left shoulder including partial-thickness rotator cuff tear, left arthroscopic subacromial decompression and debridement on adhesions on November 25, 2013. She then started aggressive postoperative rehab one week after the surgery with extremely good efficacy. She was doing well with the shoulder with 1/10 pain. Regarding the back, she had persistent back and right lower extremity radicular symptoms. evaluated her on September 4, 2013, and diagnosed her with pseudo sciatica and*

recommended left-sided facet blockade at L5-S1 on a diagnostic/ therapeutic basis. Gabapentin was prescribed. The patient currently had pain of 4/10 in the back area and left lower extremity radicular-type symptoms. The pain was pulling and throbbing and indicated symptoms were all the way from her buttocks down into the calf and foot on the left side. She had limitation of her activities of daily living, particularly difficulty doing laundry and negotiating stairs. She also reported limited sexual activity due to back pain.”

On March 12, 2014, evaluated the patient for 4/10 throbbing pain in the lower back. Her left shoulder symptoms had resolved. In the low back, she had limited range of motion (ROM) and pain radiating down the left leg. The numbness and tingling had resolved. She had popping in the lower back on walking. She had pain across the right side going away when the back popped again. Examination revealed muscle spasm along the paraspinal muscles and tenderness. Sitting straight leg raise (SLR) was positive on the left. X-ray of the left shoulder revealed minimal osteoarthritis at the AC joint suggesting repetitive motion injury. Lumbar x-rays were negative. diagnosed left lumbar sprain, left AC joint ligament sprain, spasm of muscle and sprain of left shoulder and upper arm. The patient was advised to continue PT and restricted duty. She was referred for an epidural steroid injection (ESI).

On March 21, 2014, and March 28, 2014, the patient underwent PT with modalities of therapeutic exercises, neuromuscular re-education and therapeutic activities.

On April 4, 2014, performed a MMI/IR evaluation and opined the patient not be at MMI, as treatment was pending for the lumbar spine.

On April 16, 2014, noted the low back pain to be 5/10. The patient was awaiting approval for ESI. She was recommended no PT and no medications. She was to continue restricted duty.

On April 23, 2014, evaluated the patient for low back pain radiating to her left leg to the foot. She would have tingling or numbness in the left leg. The pain would worsen at night and rated it at 5/10. She reported some burning at times in the side or left thigh. She reported popping in her back as well. Examination of the back revealed tenderness in the lumbosacral spine and paraspinals diffusely. The lumbar ROM was forward flexion 35 degrees, extension 10 degrees both with discomfort and bilateral lateral flexion 25 degrees. Motor strength was 4+/5 in left flexion secondary to pain limiting full effort. Reflexes were symmetrical at 1-2 in the patella and 1 in the Achilles bilaterally. There was a negative SLR in sitting position to 90 degrees. diagnosed left shoulder sprain/strain status post rotator cuff tear, status post left shoulder surgery doing well, lumbosacral sprain/strain, rule out left lower extremity radiculopathy and possible lumbar facet pain. The patient recommended continuing previous home exercise program (HEP), continuing modified duty work release and return as needed. A referral for evaluation of facet injection and consideration of ESI by interventional specialist was made. Following the ESI, noted the patient to be an appropriate candidate

for functional capacity evaluation (FCE) and entry into a modified work hardening program.

On May 13, 2014, evaluated the patient for ongoing issues. The patient reported 4/10, aching and shooting back pain radiating into the left leg with burning distribution. The pain was constant and was aggravated by bending, driving for long periods of time, lifting, sitting/standing for long periods of time, walking, running, reaching and grabbing. It was alleviated by rest and ice. She also reported occasional numbness in the left lower extremity with prolonged sitting. There was history of AC separation and back pain. The review of systems was positive for weight gain, back pain and muscle cramps. Examination of the back revealed tenderness over bilateral lumbar facets, mildly reduced ROM with facet loading and mild pain, positive Faber test on the left and positive Gaenslen test on left. diagnosed lumbago and recommended facet/MBB injection to the lumbar spine followed by three PT sessions.

On June 13, 2014, performed a left L5 and S1 medial branch block of the primary dorsal rami to the lumbar facets with interpretation of contrast under fluoroscopic guidance.

On June 26, 2014, the patient reported that she had 80% temporary benefit from the lumbar paravertebral facet injection. She continued with symptomatology. diagnosed lumbago and lumbar herniated nucleus pulposus (HNP) without myelography and recommended lumbar/sacral rhizotomy followed by three sessions of PT.

From July 8, 2014, through September 11, 2014, the patient underwent PT at Premier Physical Therapy with modalities to include therapeutic activity, therapeutic exercises, manual therapy and electrical stimulation.

On July 25, 2014, performed radiofrequency ablation (rhizotomy) of the medial branch of the primary dorsal rami of the left L5 and sacral ala nerve roots under fluoroscopic guidance. Electrical stimulation guidance was performed prior to rhizotomy.

On August 14, 2014, noted the lumbar radiofrequency ablation was partially effective. She was utilizing ibuprofen at nighttime and it made her sleepy. Examination of the back revealed left-sided bony tenderness present in the mid lumbar region of L3 and L4. There was mildly reduced ROM with facet loading. Faber and Gaenslen test was positive on the left. recommended facet/MBB to lumbar spine.

On December 9, 2014, the patient reported 3/10 low back pain and left leg pain. The pain was shooting, burning and pulling quality radiating to the buttocks and thighs. The pain went to 7-8/10 upon prolonged standing/walking. Her legs felt fatigued. Examination of the lumbosacral spine revealed tenderness to palpation. There was mildly reduced ROM with mild pain on facet loading. SLR was positive on left. Faber and Gaenslen were negative bilaterally. Waddell's signs were not

present. Ankle reflexes were 1+. Gait was antalgic. recommended lumbar ESI followed by three sessions of PT. Transforaminal ESI under fluoroscopy at left L5 and S1 was discussed which the patient agreed.

Per a utilization review dated December 15, 2014, the request for OP left L5-S1 transforaminal ESI with epidurography under fluoroscopy and sedation (64483, 64484, 72275, 77003 and 99144) was denied with the following rationale: *“The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The Official Disability Guidelines recommend epidural steroid injection as a possible option for short-term treatment of radicular pain, with use in conjunction with active rehab efforts. Radiculopathy must be documented by a physical examination and corroborated by imaging studies and/or electrodiagnostic testing. As per the documentation submitted, the patient underwent an electrodiagnostic study on August 21, 2013, which revealed normal findings. There was no electrodiagnostic evidence of radiculopathy. Additionally, the medical necessity for sedation has not been established. As such, the request is non-certified.”*

Per a reconsideration review dated January 15, 2015, the appeal OP left L5-S1 transforaminal epidural steroid injection with epidurography under fluoroscopy and sedation (64483, 64484, 72275, 77003 and 99144) was denied with the following rationale: *“The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The mechanism of injury was noted as assisting a client out of a shower chair. Medications were not stated. Her surgical history includes a left shoulder surgery dated November 25, 2013. Diagnostic studies include an official MRI of the lumbar spine dated July 9, 2013, which revealed exaggerated lordosis of the lower lumbar spine centered at approximately L5, with associated mild bilateral L5-S1 lateral recess/subarticular narrowing. No canal stenosis was seen. The official electrodiagnostic studies dated August 21, 2013, revealed normal findings. Other therapies include physical therapy treatments and medial branch blocks, with a radiofrequency ablation at left L5 on July 25, 2014. The patient is a female who reported a work-related injury on xx/xx/xx. The most recent clinical note submitted is dated August 14, 2014, which stated the patient presented with low back pain and left leg pain. She stated the pain radiated to her left buttock and thigh. The patient had been treated with lumbar radiofrequency ablation, which had been partially effective. The patient continued to attend physical therapy. The physical exam of the lumbar spine revealed left-sided bony tenderness present at mid lumbar region at L3-4. Her range of motion was mildly reduced, with mild pain on range of motion with facet loading. Faber test was positive on the left, Ganenslen’s test was positive on the left, and Waddell’s signs were not present. The motor strength to the bilateral lower extremities was within normal limits, and sensations were intact to light touch and pinprick in extremities. The patient’s gait was normal. The treatment plan included a medial branch block injection. The Official Disability Guidelines criteria for epidural steroid injection includes that radiculopathy must be documented, with objective findings on examination and corroborated by imaging studies or electrodiagnostic testing. Per the submitted MRI, there was no documentation of cord or nerve root compromise, and no findings of radiculopathy*

per electrodiagnostic studies. In addition, there were no clear cut findings of radiculopathy, which would identify specific nerve root compromise on the patient's physical exam, as the patient was not noted to have sensory or motor loss in a specific dermatome or myotome. A more recent clinical note which addressed the proposed treatment was not submitted for review. Additionally, there was no rationale provided for the request for sedation. Prior utilization review dated December 15, 2014, stated there was no electrodiagnostic evidence of a radiculopathy and the medical necessity for sedation had not been established. Given the above the request for OP left L5 and S1 TF ESI, epidurography, fluoroscopy, sedation, 64483,64484,72275,77003, and 99144 is non-certified. There were no clear-cut findings of radiculopathy, which would identify specific nerve root compromise on the patient's physical exam, as the patient was not noted to have sensory or motor loss in a specific dermatome or myotome and no recent clinical note which addressed the proposed treatment."

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

There are no clear-cut signs of radiculopathy and no rationale for epidurography. Therefore, it does not fall within the guidelines.

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