



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Date notice sent to all parties: 05/29/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L4-L5 transforaminal epidural steroid injection (ESI)

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal Surgery

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Right L4-L5 transforaminal ESI - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

A lumbar MRI dated 11/10/14 revealed a posterior central 5 mm. herniation at T12-L1 and additional imaging, such as a thoracic MRI was recommended. There were both advanced chronic degenerative changes at L4-L5 with a moderate 5 mm. left posterolateral herniation. The herniation contacted the left L5 nerve. examined the claimant on 11/14/14. It was noted her MRI showed a left herniation at L5. She was not interested in therapy and any position made her pain worse. She had decreased lumbar range of motion and tenderness in the low back. Sensation was intact and

strength was 5/5 in the bilateral lower extremities. The DTRs were 1 in the bilateral lower extremities. The diagnoses were a lumbar sprain and displacement of the lumbar intervertebral disc without myelopathy. Physical therapy was recommended and a Medrol Dosepak was prescribed. Ibuprofen was discontinued and Naproxen was prescribed. An EMG/NCV study was also performed that day and was noted to be abnormal. There was no electrophysiological evidence of lumbosacral radiculopathy. There was an abnormal lower extremity sensory nerve study that implied the early signs of polyneuropathy. performed a Designated Doctor Evaluation on 01/14/15 to determine MMI, an impairment rating, and extent of injury. She had pain in the right side of her lower back that radiated to the back of her thigh and then came around the thigh in a band toward the front and inner side of the knee. It went back behind the knee and traveled down the calf area all the way to the foot. She also had numbness and tingling all the way down to the foot. She noted sometimes her foot became numb and she felt like she walked on rocks. She was injured on 10/21/14 when she was lifting pallets of salt that weighed about 40 pounds and was taking them off the shelf and was turning without walking or moving. After lifting and moving three to four pallets, she felt a pop in her lower back on the right side followed by severe pain traveling down her right leg seconds later. She had not returned to work because they could not accommodate her restrictions. She was five feet seven inches tall and weighed 180 pounds. She walked slow when she bore weight on the right leg, but her gait was not abnormal. She had some tenderness at the very base of the spine toward the right, but there were no spasms, tightness, or trigger points. She did well with range of motion and straight leg raising caused pain on the right. DTRs were 2+ and equal bilaterally at the knees and ankles. Strength-wise, she did not give full resistance when doing her hip and knee extensors. She stated there was a lot of pain in the lower back that radiated down her right leg with this. could not determine if this was a motor issue or only due to pain. Sensory exam revealed non-physiological loss of perception in the right leg. The accepted diagnosis was a lumbar strain and the disputed diagnoses were an T12-L1 disc herniation and degenerative changes at L4-L5. noted there was some radiculopathy, but he could not determine the level and noted when looking at the MRI, the findings were a left herniation at L4-L5 and not on the right. He also noted there was no radiculopathy on exam, but there was definite radiculitis on exam. A CT myelogram was then obtained and after reviewed it, he noted there was not much difference and none of the disputed conditions were what was causing her symptoms and signs. Therefore, her extent of injury was a lumbar sprain/strain and radiculitis without radiculopathy. He did not feel she had reached MMI and required further treatment. A lumbar CT myelogram was obtained on 02/11/15. At L4-L5, there was a 5 mm. left posterolateral broad based disc and mild bilateral facet joint hypertrophy that just abutted the L5 nerve roots in the bilateral L4-L5 lateral recesses, left worse than right, without central stenosis or neural foraminal narrowing. At T12-L1, there was a 5 mm. left paracentral disc indenting the ventral thecal sac without central stenosis, cord compression, or neural foraminal narrowing. At L5-S1, there was no focal disc abnormality with mild bilateral facet joint hypertrophy. examined the claimant on 02/20/15. He noted she had no left sided pain or numbness. On exam, she had no tenderness, decreased range of motion, instability, or abnormal strength. Strength was 4/5 on the right EHL and quadriceps and sensation was diminished on the right at L4 and L5. She had a hyporeflexive knee jerk on the right. Straight leg raising was normal. The MRI and CT myelogram were reviewed and noted it was hard to explain

her right sided pain, as the studies only showed disc herniation on the left. He felt she might have a stretch injury of the right sided L4-L5 roots and an ESI at L4-L5 was recommended. noted she was not a surgical candidate. examined the claimant on 03/10/15. It was noted the EMG/NCV study was not available for review, the myelogram and MRI were. She was currently on Neurontin 300 mg. three times a day. She had received five sessions of therapy and had used a TENS unit with no benefit. Strength was normal in the bilateral lower extremities, as were the reflexes at 2+. Sensation was reduced to light touch on the right at L4-S1. She had spinous process tenderness at L4-S1 and straight leg raising was negative. The assessments were back pain with radiation and displacement of the thoracic or lumbar intervertebral disc without myelopathy. noted her studies showed issues on the left, but her symptoms were on the right. He also noted there were neurological deficits on the right per his exam and a right transforaminal ESI at L4-L5 was recommended. On 03/24/15, on behalf of , provided an adverse determination for the requested right L4-L5 transforaminal ESI. On 04/30/15, provided another adverse determination for the requested right L4-L5 transforaminal ESI.

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

The multiple imaging studies performed, including a lumbar MRI and CT myelogram, demonstrated that the claimant has neurological compression from a left posterior central herniation at L4-L5. The CT myelogram showed there is a left sided compression. The claimant's complaints are right sided and it has been noted by multiple physicians who have evaluated her that her complaints are right sided, but her diagnostic studies show findings on the left. The ODG requires objective evidence of radiculopathy as a criteria for ESIs. The EMG/NCV study was negative for lumbosacral radiculopathy and the physical examinations are not consistent with any compression on the left nerves, although the claimant's symptoms are contralateral to her compression. Furthermore, normal strength and normal DTRs of the bilateral lower extremities was documented throughout the records reviewed. In fact, , the Designated Doctor indicated the patient had a non-physiological loss of perception in the right leg. Therefore, from an anatomic basis and a physiological basis there is no indication for the ESI. If the claimant is not a candidate for surgical decompression, the claimant is not a candidate for an ESI, as the criteria in the ODG are the same for both. There must be definable and objectively radiculopathy and there must be compression from the nerves. In this case, neither was present. Therefore, the requested right L4-L5 transforaminal ESI is not reasonable, necessary, or in accordance with the criteria of ODG. The adverse determinations should be upheld at this time.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)