

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

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L4, L5, S1 epidural steroid injection with total intravenous anesthesia (TIVA) (64483, 64484, 77003, 01992).

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:

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an industrial injury on XX/XX/XXXX. The patient was holding a water hose and suddenly a sledgehammer fell from 200 feet hitting her left shoulder and causing her to lose balance and fall on the left side.

On November 6, 2013, the patient underwent a magnetic resonance imaging (MRI) of the left shoulder. The study showed soft tissue edema superior to the AC joint and the superior aspect of the shoulder.

From January 2, 2014, through January 22, 2014, the patient attended therapy at consisting of therapeutic activities, therapeutic exercises and manual therapy.

An MRI of the lumbar spine without contrast dated May 21, 2014, showed: 1) At L4-L5, there was

broad based posterior protrusion-subligamentous disc herniation in the central and lateral aspect in both sides measuring 5-5.5 mm in AP diameter, moderately indenting the thecal sac. There was mild decreased signal of this disc indicative of dehydration and desiccation but the disc space was not narrowed. There was slight to moderate inferior neural foraminal stenosis bilaterally at this level, left more than the right. 2) At L5-S1, there was broad based posterior protrusion-subligamentous disc herniation in the central and paracentral region measuring 2.6 mm in AP diameter, not reaching the thecal sac. 3) Incidentally noted was a markedly enlarged uterus with multi-uterine fibroids. The uterus extends up to the L3-L4 level of the lumbar spine. The fibroids range in size from 1.4 cm, 2.2 cm, 5.2 cm and as much as 7 cm.

An MRI of the cervical spine on May 21, 2014, showed at C3-C4, posterior protrusion-subligamentous disc herniation in the central and paracentral region measuring 2.8 mm AP diameter, indenting the thecal sac and almost reaching the spinal cord. Posterior bulging was noted at C5-C6 and C6-C7.

On September 9, 2014, evaluated the patient for pain in the left shoulder described as stabbing, constant. The patient stated she was getting worse in the cervical spine and lumbar spine. the claimant tried pain medication. the patient stated she had participated in five to six sessions of PT but this was stopped due to swelling in the left trapezius. The following tests were positive on orthopaedic examination: cervical distraction, maximum cervical compression, shoulder depression, Supraspinatus, Yergason's, Apley's scratch test, double leg raise and straight leg raising (SLR). Cervical spine revealed mild-to-moderate spasms, tenderness, decreased ROM and tension. The lumbar spine also revealed similar findings.

In a functional capacity evaluation (FCE) dated October 8, 2014, the patient qualified at the sedentary physical demand level (PDL) and failed to meet the minimum job requirements of a fire watch worker, which was a heavy PDL.

On October 9, 2014, reviewed the FCE findings and scheduled the patient for a mental health evaluation and for pain management.

performed a designated doctor evaluation (DDE) on November 4, 2014, and determined the patient had not reached maximum medical improvement (MMI). Regarding extent of injury, the compensable injuries that were accepted were left shoulder contusion, left shoulder impingement and brachial plexus. The cervical sprain/strain and lumbar sprain/strain would also be accepted from her fall to the ground. Her cervical and lumbar disc protrusions and bulges would at the most have been aggravated by the mechanism of injury. The mechanism of injury would not normally bring on all the protrusions and bulges the patient demonstrated on the MRI. concluded the patient's protrusions and bulges were aggravated by the mechanism of injury and could have permanent ramifications if not addressed. Therefore, they were compensable. stated she was not sure about the patient's complex regional pain syndrome (CRPS) but suspected that it would be the same.

The patient had follow-ups with on January 28, 2015, and March 4, 2015. The plan included referral

to orthopedics for cervical sprain and to pain management for the lumbar strain. The patient was released to full time light duty and was advised to continue home exercises.

On April 8, 2015, evaluated the patient for pain in the cervical spine, lumbar spine and left shoulder. Regarding the lumbar pain, she described it as tightening and aching. The patient had tried rest and medications at home for pain. It was noted the patient had undergone a vascular surgery on her left lower leg. It was noted the patient had a magnetic resonance imaging (MRI) and electrodiagnostic studies and underwent 16 sessions of physical therapy (PT). Examination showed 1+ pitting edema in the left lower leg. There were moderate spasms, tenderness and decreased range of motion (ROM) in the lumbar spine. The diagnoses were cervical radicular syndrome, radicular syndrome of the lower limbs, rotator cuff syndrome, sprain of shoulder and upper arm, acute cervical sprain and lumbar strain. Recommended the patient to finish the remaining sessions of PT. He referred her to pain management for evaluation for medications. The patient was released to full time light duty for eight weeks.

On June 8, 2015, evaluated the patient for neck, left shoulder and back pain. The patient complained of low back pain radiating into the bilateral lower extremities, left greater than right. She indicated numbing and tingling sensations on the left lower extremity. She rated her pain level as 10/10 without medications and 5/10 with medications. The patient reported her pain was provocative with sitting, walking and standing, and palliative with medications and lying down. She described her pain as aching, stabbing, electrical, burning and sharp. The patient reported she had received an IM injection on her buttock for the pain, which did help lessen her pain; however, it took some time. Medications included albuterol, cyclobenzaprine, Diovan, hydrocodone, naproxen and Symbicort. It was noted that the patient had been treated with chiropractic treatment, massage therapy, medication and physical therapy without improvement. The patient also complained of neck pain with radiation pain into the left shoulder. Lumbar examination noted bilateral paraspinal and piriformis trigger points. The lumbar range-of-motion was limited to flexion, right axial loading and left axial loading. There was spinous tenderness in the bilateral L3-S1. There was facet tenderness in the bilateral L2-S1. Facet loading was positive bilaterally. Straight leg raise (SLR) was positive in the right at 35 degrees, and left 20 degrees. There was sacroiliac (SI) joint tenderness and sciatic notch tenderness, bilaterally. Motor strength noted left 3/5 hip flexion, knee extension, dorsiflexion, plantarflexion and right 4/5 at hip flexion (severe pitting edema in the left lower extremity). Sensation was intact throughout. There was decreased sensation in the left L4-S1. The deep tendon reflexes noted absent left patellar, bilateral Achilles and 1+ right patellar. The diagnoses were lumbar sprain/strain, shoulder sprain/strain and cervical sprain/strain. Recommended a left lumbar epidural steroid injection (ESI) at L4, L5, and S1 with total intravenous anesthesia (TIVA) due to patient's anxiety and depression.

On June 17, 2015, stated the patient was pending an ESI with.

On July 7, 2015, noted the patient complained of back pain; the pain had gradually been increasing. The patient reported her back pain radiated into the bilateral lower extremities, left greater than right. She indicated numbing and tingling sensations on the left lower extremity. She rated her pain

level as 10/10 without medications and 5/ 10 with medications. She described her pain as aching, stabbing, electrical and burning. The patient reported her pain was provoked by sitting, waking and standing and alleviated with medications and laying down. Mobic was helping with the swelling in both feet. The patient had neck pain that radiated to the left shoulder associated with numbness and tingling in the left arm. It was noted the patient has not had any lumbar ESI or any surgical intervention on her lower back. The patient had received an IM injection on her buttock, which helped lessen her pain; however, it took some time. Physical examination noted the gait was antalgic and she used a cane. Lumbar spine examination revealed trigger points in the bilateral paraspinal muscles and piriformis. The ROM was limited with flexion, right axial loading and left axial loading. There was spinous tenderness on the bilateral L2-L3, L3-L4, L4-L5 and L5-S1. There was facet tenderness in the bilateral L2-L3, L3-L4, L4-L5 and L5-S1. Facet loading was positive bilaterally. SLR test was positive at 20 degrees in the left side and 35 degrees on the right. Faber was positive bilaterally. There was SI joint and sciatic notch tenderness bilaterally. Motor testing noted left hip flexion, left knee extension, dorsiflexion and plantar flexion were 3/5, and severe pitting edema in the left lower extremity and hip flexion was 4/5. Sensation was decreased in the left L4, L5 and S1. The DTRs in the left patellar and bilateral Achilles were absent and right patellar was +. There was left lower extremity swelling and 2+ edema. The recommendation was left lumbar ESI at L4, L5 and S1 with TIVA due to patient's anxiety and depression.

In a pre-authorization determination dated July 10, 2015, denied the request or left L4, L5, S1 ESI with TIVA. Rationale: *"In my judgment, the clinical information prodded does not establish the medical necessity of this request. With the submitted documentation, there appeared to be a radiculopathy on the left that appeared to span several different nerve root levels, but there was no corroboration from imaging. The Official Disability Guidelines Low Back Chapter regarding criteria for ESIs does not recommend more than two levels of epidural steroid injection at any one time. There appeared to be documentation to support the need for sedation, including anxiety and depression, particularly the anxiety; however, because more than three levels are requested and there is no corroboration from imaging, medical necessity could not be established for left L4, L5, S1 epidural steroid injection with TIVA--total intravenous anesthesia."*

On July 13, 2015, was notified of the denial of the left L4, L5, and S1 ESI with TIVA.

In a letter dated July 15, 2015, an appeal was made for reconsideration (appeal) of the adverse determination for left lumbar epidural steroid injection (LESI) L4, L5 and S1 with TIVA. The provider reported that the patient's condition was deteriorating because of the refusal to approve the left LESI, which was preventing the medical provider from fully utilizing the necessary treatment options to allow the patient to reach maximum medical improvement.

In an appeal determination on July 20, 2015, the request for left L4, L5, S1 ESI with TIVA was denied. Rationale: *"In my judgment, the clinical information provided does not establish the medical necessity of this request. The treatment notes indicate multilevel dermatomal distribution sensory loss; also broad distribution strength loss to the lower extremity on recent examination on June 8, 2015. This appears to be acute change in these findings compared to the April 8, 2015,*

treatment note. I do not have information that there is supporting evidence of the Official Disability Guidelines Low Back - Lumbar % Thoracic Chapter, section regarding Lumbar epidural steroid injection which indicates conservative measures of treatment should be conducted prior to the epidural steroid injection, including exercises, physical therapy, and medications. There is discussion of previous physical therapy in the past, but I do not have a report regarding type and extent of recent comprehensive conservative approach to treatment before the requested procedure. Also, the guidelines do not support greater than two level epidural steroid injection treatment. This appears to be a three level request in terms of epidural steroid injection. Also, the criteria are not established in the guidelines which also include corroborating imaging studies need to support a radiculopathy. The MRI poorly conducted does not show evidence of nerve root entrapment at the three levels requested as well. Therefore, the request for left L4, L5 and S1 epidural steroid injection with TIVA--total intravenous anesthesia with CPT codes: 64483, 64484, 77003 and 01992 is not reasonable or medically necessary."

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

The patient has neurological deficits related to a lumbar disc injury and so epidural injections are medically necessary. The request is ambiguous because the codes do not match the verbal portion. The transforaminal epidural is medically necessary at only 2 of the three possible levels, thus a 2 level injection is appropriate, and matches the codes requested. However, a third simultaneous injection is not medically necessary, nor is supported by the ODG. Also, there is no documentation which meets ODG/ medical necessity for the TIVA, as this procedure can be safely and effectively performed with/without anesthesia, with/without conscious sedation, and without Monitored Anesthesia Care.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES