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DATE OF REVIEW: AUGUST 31, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Caudal Epidural Steroid Injection L4-L5 under fluoroscopy with IV Sedation (62311, 77003)

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
847.2	62311		Prosp	1			XX/XX/XX	XXXXXXXXXXXX	Upheld
847.2	77003		Prosp	1			XX/XX/XX	XXXXXXXXXXXX	Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

evaluated the injured employee on September 24, 2014. He was in a car that slid off the road and flipped a couple of times. He sustained a possible loss of consciousness for a few seconds and was dazed for a while. The injured employee had complaints of low back, right shoulder, right hand pain rated 8/10 on the visual analog scale (VAS) with tingling and numbness present, and pain radiating down the back and both legs. The physical examination demonstrated he was alert; oriented to person, place, and time; and in no apparent distress, with a normal affect. He had a normal gait. The cranial nerves II-XII were intact. The Romberg's test was normal and his head was normocephalic and nontraumatic. The ears, nose, and throat were within normal limits. The heart had a regular rate and rhythm, and the lungs were clear to auscultation bilaterally. The physical examination of the cervical spine demonstrated a decreased range of motion in all

planes. The deep tendon reflexes were normal, sensation was normal, and motor strength was normal.

The physical examination of the right shoulder demonstrated a decreased range of motion in all planes with diffuse tenderness. The lumbar spine demonstrated a decreased range of motion in all planes with muscle spasms in the lumbar paraspinal muscles bilaterally. The deep tendon reflexes and sensory examination were normal. The bilateral seated straight leg raise testing was negative. The finger to nose examination was normal. X-rays of the cervical spine were performed, and were reported as negative for fracture and dislocation. X-rays of the right shoulder were reported as negative for fracture and dislocation. X-rays of the lumbar spine were reported as negative for fracture and dislocation. The assessments were a bilateral headache, a bilateral sprain of the lumbar spine, a bilateral sprain of the neck, right shoulder region traumatic arthropathy, and a bilateral sprain of the coccyx. The recommendation was for a CT of the head, with no physical therapy and no medications required. The injured employee was instructed to follow-up in two days and precautions were provided. The CT of the head performed on September 24, 2014, was noted to report no evidence of hemorrhage, extra-axial fluid, infarct edema, or brain stem abnormality.

In a follow-up for the head injury at on October 3, 2014, the injured employee reported that symptoms had decreased overall. There was no report of headache on that date. The recommendation was for no medications and no physical therapy until after an evaluation and recommendation by orthopedics regarding the low back. Ultracet was prescribed.

evaluated the injured employee on October 10, 2014, for neck, low back, and right shoulder pain as well as right hip pain. The physical examination of the cervical spine demonstrated a good range of motion but pain with flexion and extension. Reflexes were normal in the bilateral arms. There were no motor or sensory deficits noted in the upper extremities, and no muscle atrophy. The right shoulder had pain with abduction greater than 60 degrees and tenderness over the medial external area. There was pain with attempts on range of motion in all directions of the shoulder. The lumbar spine examination demonstrated positive straight leg raise testing at 45 degrees bilaterally. There were no lumbar spasms. The injured employee's gait was normal. The deep tendon reflexes were normal in the bilateral lower extremities. There was no atrophy. The right hip pain appeared to be related to the low back and not in the right hip joint. The assessment was a cervical strain, a lumbar strain, and a right shoulder strain. The recommendation was for a physical therapy evaluation and treatment, a psychological intake evaluation, and a Functional Capacity Evaluation.

A physical performance evaluation was performed on October 17, 2014, and the outcome noted the injured employee could not safely perform his job demands based upon the comparative analysis between the required job demands and the current evaluation outcomes. The injured employee was advised to continue care with the treating doctor and it was noted that he would benefit from participation in an active physical therapy program.

The clinical notes from dated November 3, 2014, reported the injured employee was being evaluated for neck, shoulder, and low back pain from a motor vehicle accident. The physical examination demonstrated decreased range of motion of the cervical spine. A mild Tinel's sign was noted at the bilateral wrists. There was decreased grip strength. Trigger point tenderness was noted through the interscapular lumbar regions. There was no ankle clonus and no sudomotor or vasomotor changes were noted. Lumbar flexion was 60 degrees for reproduction of back pain and 30 degrees on extension. Increased paraspinal muscle tone was noted. Trigger point tenderness was noted throughout the lumbar interscapular and rhomboid regions. The toes were downgoing and no ankle clonus was elicited. There was tenderness over the bicipital groove of the right shoulder as well as

mild tenderness at the acromioclavicular joint (ACJ) with decreased abduction of the right shoulder. The assessments were a subacute pain syndrome of the cervical, mid-thoracic, and lumbar regions; could not rule out traumatic bilateral carpal tunnel syndrome (CTS); could not rule out right shoulder internal derangement; and wait for MRI results. The recommendation was a combination of neuropathic as well as nonsteroidal anti-inflammatory drug (NSAID) support; Ibuprofen, Gabapentin, and Amitriptyline were prescribed.

An MRI of the right shoulder was performed on November 4, 2014, and the impression, as reported by, was:

1. Prominent supraspinatus hypertrophic tendinopathy with articular surface fraying and mild attenuation of the critical zone fibers, moderate infraspinatus hypertrophic tendinosis,
2. Articular surface and interstitial partial tearing of the superior distal subscapularis measuring 12 mm wide,
3. Interstitial biceps tendinopathy and a mild, partial tearing of the prominent heterogeneous tenosynovitis; biceps tendon fibers were perched on the lesser tuberosity without frank subluxation; degenerative labral tearing,
4. Severe traction spurring, capsular hypertrophy, and reactive edema at the ACJ,
5. Moderate prominent subacromial/subdeltoid bursitis, and
6. Small heterogeneous reactive joint effusion.

In addition, an MRI of the lumbar spine was performed on December 22, 2014, and the impression, as reported by, was:

1. Mild disc space narrowing, endplate changes at L4-L5,
2. Disc bulge and facet hypertrophy of L2-L3 resulting in mild spinal canal, right lateral recess, and minor neuroforaminal narrowing,
3. Disc bulge and facet hypertrophy at L3-L4 resulting in mild-to-moderate spinal canal and mild bilateral neuroforaminal narrowing at L3-L4,
4. Disc bulge and facet hypertrophy at L4-L5 resulting moderate spinal canal and moderate-to-severe bilateral neuroforaminal narrowing, and
5. Disc bulge at L5-S1 contacted the exiting S1 nerve roots bilaterally; combined with facet hypertrophy, there was moderate bilateral neuroforaminal narrowing.

evaluated the injured employee on December 31, 2014, for an evaluation only; not for care, treatment, or consultation. The physical examination demonstrated no tenderness to palpation of the cervical and lumbar spine. There was no tenderness to palpation of the coccyx. The injured employee reported it only hurt when standing and did not hurt upon palpation. There were no muscle spasms or trigger points in the entire spine. There was normal lordosis in the entire spine. The range of motion was full in the cervical and lumbar spine. There was no tenderness to palpation, joint crepitation, swelling, spasms, or joint subluxation in the upper extremities, except for some mild tenderness over the right ACJ and some mildly positive impingement signs bilaterally, right greater than left. The Hawkins test and Neer's sign were positive. There was mild pain with cross body adduction. There was no edema in the lower extremities and no tenderness to palpation, crepitation, or swelling in any other joints in the lower extremities bilaterally. There was a full range of motion of all joints in the lower extremities with no obvious leg length discrepancies. The deep tendon reflexes were 2+ bilaterally in the upper and lower extremities. The sensory examination was intact to light and sharp touch, vibration, and two-point discrimination in the bilateral upper and lower extremities. The assessment was a lumbar sprain, cervical sprain, right shoulder sprain,

and coccyx sprain. opined that, based on the documentation provided, the mechanism of injury, and physical findings, the injured employee sustained a lumbar sprain, a cervical sprain, a right shoulder sprain, a coccyx sprain, and a concussion with a brief loss of consciousness as the extent of injury. placed the injured employee at Maximum Medical Improvement as of December 2, 2014, noting that while the injured employee was still symptomatic, most likely from pre-existing, degenerative conditions in all those areas, those injuries would not likely respond to further treatment; and all reasonable treatment interventions had been administered for the work injury according to the Official Disability Guidelines by December 2, 2014. Using the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fourth Edition, determined the injured employee had a 5% Whole Person Impairment Rating.

The injured employee was evaluated at on January 7, 2015, for the right shoulder pain. The physical examination of the right shoulder demonstrated abduction strength was 3+/5, forward flexion was 4-/5, extension was 4+/5, external rotation was 4-/5, and internal rotation was 5/5. There was a negative lift off sign but it was painful. The subscapularis was weak. Forward flexion was 130 degrees, abduction was 80 degrees, extension was 28 degrees, and internal rotation was to L5. There was tenderness to palpation along the long head biceps tendon, tenderness in the intertubercular groove, and tenderness along the coracoid process and the anterior aspect of the glenohumeral joint. The right upper extremity was neurovascularly intact. There was a painful arc of motion. The assessments were a significant right shoulder injury, with a dislocation of the long head biceps tendon, a partial tear of the long head biceps tendon along with the anterior aspect of the right shoulder in the extra-articular position, as well as partial tearing of the supraspinatus, infraspinatus, and subscapularis rotator cuff tendons. The recommendation was for a right shoulder rotator cuff repair.

evaluated the injured employee on February 3, 2015, for low back pain. He reported the pain occurred constantly. The pain was made worse, with a burning quality, by walking or standing for any extended period. The injured employee reported he had not had any physical therapy or injections for the lumbar spine. The injured employee reported a previous L4-L5 laminectomy in 1995 and right shoulder surgery in 1996. The physical examination of the lumbar spine demonstrated a normal gait. There was midline tenderness in the lower lumbar spine. The range of motion was painful. The deep tendon reflexes were 2+ in the quadriceps and 1+ in the Achilles bilaterally. The motor strength examination was 4 in the anterior tibialis, extensor hallucis longus, and gastroc soleus bilaterally. The straight leg raise testing was positive bilaterally. The assessment was an L4-L5 and L5-S1 herniated nucleus pulposus. The recommendation was for L4-L5 and L5-S1 epidural steroid injections (ESIs).

The injured employee underwent a behavioral medicine consultation on February 16, 2015. The recommendation was for a brief course of individual psychotherapy intervention using cognitive behavior therapy approaches and basic self-management strategies coupled with autogenic exercise to facilitate a healthy adjustment and coping with the overall condition. It was noted that the injured employee should receive immediate authorization for participation in low-level, individual psychotherapy for a minimum of four weeks. He continued to be seen by through April 6, 2015.

Medical notes from dated February 16, 2015, reported the injured employee was being evaluated to determine whether or not he had reached Maximum Medical Improvement, and if it had been reached, then for an Impairment Rating to be assigned. It was noted that the injured employee had not reached Maximum Medical Improvement from the on-the-job injury and he should be allowed to follow up with an orthopedic surgeon for the shoulder injury. The injured employee should reach Maximum Medical Improvement in four months.

A request was made for lumbar ESIs at L4-L5 and L5-S1, and had been certified by on March 5, 2015.

There was a denial for a caudal ESI at L4-L5 under fluoroscopy with intravenous sedation on June 18, 2015, by, noting the injured employee underwent a prior ESI at L4-L5 and L5-S1 and there were no follow-up notes indicating the injured employee's response to those injections.

Finally, there was a prior non-certification by on July 17, 2015, noting there was no current detailed physical examination submitted for review to establish the presence of radiculopathy, as required by the Official Disability Guidelines.

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

As noted in the Division-mandated Official Disability Guidelines Low Back Chapter, updated July 17, 2015, the Guidelines indicates there should be evidence of radiculopathy on physical examination that can be corroborated by diagnostic imaging and/or electrodiagnostic testing; and the individual should be unresponsive to conservative care. In the therapeutic phase, repeat injections are not indicated unless there has been documentation of pain relief of 50% to 70% for at least six to eight weeks after the previous injection, with documentation of a decreased need for pain medications and a functional response. None of this was noted in the documentation provided for review.

The injured employee underwent recent L4-L5 and L5-S1 ESIs, but there was no follow-up documentation noting the injured employee's response from the injections. There was no current clinical note provided for review documenting radiculopathy that was corroborated with imaging. There was no indication electrodiagnostic studies were performed. Based upon the documentation reviewed, the recommendation for a caudal ESI at L4-L5 under fluoroscopy with intravenous sedation would not be supported. There was no documentation noting the injured employee had severe anxiety, requiring the need for intravenous sedation or that the injured employee had intravenous sedation with the previous ESIs provided.

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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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 MANUA
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)