Health Decisions, Inc.

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
64483, 64484, 72275, 72020, 01936, J3490

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board certified in Orthopedic Surgery since 2008

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

☒ Upheld (Agree)

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]:
Patient is a XXXX who presents with lower back pain that radiates down bilateral legs. Provider is requesting an ESI for right knee. XXXX is status post T1-S1 spinal fusion. Services requested that are being denied are: Lumbar transform bilateral L4-5, Lumbar Addt'l level bilateral L5-S1, Epidurography, Radiology, Anesthesia, and Dexlido M Kit.

XXXX – Physician Notes- **XXXX**.: Patient presents to clinic for follow up on lower back pain radiating down bilateral legs and medication refills. Patient pain level today is 7/10. Chief complaint: Lower back pain radiating down bilateral LE's. HPI: -Pain: sharp, stabbing, aching, burning, shooting; -Severity: Severe 7 of 10; -Location: Lower back and bilateral leg; -Frequency: Constant; -Triggers: When standing, when stressed, while walking, with any activity, sitting, bending, going up and down stairs; -Modifying Factors: Improves: Stopping activity, with lying down, with pain medication, with rest; -Associated Signs and Symptoms: Fatigues, stiffness and weakness; -Previous Therapies: SCS explant: Blocks-Pain relief was moderate. Plan Note: **XXXX** with chronic axial low back pain with radiculopathy and myofascial component, s/p T1-S1 spinal fusion, significant deconditioning, muscle imbalance. Patient had early XXXX SCS implanted and removed due to infection. –Patient reports that the use of XX allows 50% improvement in performance of ADLs. Denies side effects common to their use. –Continue XXXX w/2 refills to address the acute exacerbations of chronic pain. –Refill XXXX; to address the radicular and neuropathic component of pain. –Refill XXXX to address the axial and myofascial component of pain. –Continue XXXX; XXXX. –Previous XXXX collected XXXX and consistent with medication. –Return in one month for re-evaluation.

XXXX – Physician Notes- XXXX.: Patient returns to clinic to follow up on lower back pain radiating down bilateral legs. XXXX states pain scale of 9/10. Chief complaint: Lower back pain radiating down bilateral LE's. HPI: -Pain: sharp, stabbing, aching, burning, shooting; -Severity: Severe 9 of 10; -

Location: Lower back and bilateral leg; -Frequency: Constant; -Triggers: When standing, when stressed, while walking, with any activity, sitting, bending, going up and down stairs; -Modifying Factors: Improves: Stopping activity, with lying down, with pain medication, with rest; -Associated Signs and Symptoms: Fatigues, stiffness and weakness; -Previous Therapies: SCS explant: Blocks-Pain relief was moderate. Problems: Sprain of ligaments of lumbar spine, initial encounter, Status: Active, onset: XXXX. Plan Note: XXXX chronic axial low back pain with radiculopathy and myofascial component, s/p T1-S1 spinal fusion, significant deconditioning, and muscle imbalance. Pt had early XXXX SCS implanted and removed due to infection. –Patient currently stable on current meds, refills were given today. –Refill XXXX; to address acute exacerbations of chronic pain. –Refill XXXX; to address the radicular and neuropathic component of pain. –Refill XXXX; to address the axial and myofascial component of pain. –Continue XXXX; XXXX. Previous XXXX collected XXXX and consistent with medication. –Return to clinic in one month for re-evaluation.

XXXX – Physician Notes- XXXX.: Pt returns for follow up Low Back Pain radiating down BL LE's and medication refills. On a pain scale of 0/10 XXXX reports XXXX pain at 8/10. Pt requesting right knee injection. Chief complaint: Lower back pain radiating down bilateral LE's. HPI: -Pain: sharp, stabbing, aching, burning, shooting; -Severity: Severe 8 of 10; -Location: Lower back and bilateral leg; -Frequency: Constant; -Triggers: When standing, when stressed, while walking, with any activity, sitting, bending, going up and down stairs; -Modifying Factors: Improves: Stopping activity, with lying down, with pain medication, with rest; -Associated Signs and Symptoms: Fatigues, stiffness and weakness; -Previous Therapies: SCS explant: Blocks-Pain relief was moderate. Plan Note: XXXX chronic axial low back pain with radiculopathy and myofascial component, s/p T1-S1 spinal fusion, significant deconditioning, and muscle imbalance. Patient had early XXXX SCS implanted and removed due to infection. –Pt currently stable on current meds, refills were given today. Pt reports that the use of opioid medication allows 50% improvement in performance of ADLs. Denies side effects common to their use. –Refill XXXX; to address acute exacerbations of chronic pain. –Refill XXXX; to address the radicular and neuropathic component of pain. –Refill XXXX; to address the axial and myofascial component of pain. –Continue XXXX; XXXX. –I will schedule pt for MRI scan of the lumbar spine. This will allow us to evaluate this patient's current anatomy as well as the source of XXXX persistent pain despite treatment received. –Previous XXXX collected XXXX and consistent with medication. –Return to clinic in 2 weeks to discuss MRI.

XXXX – MRI Report- XXXX.: Examination: MRI lumbar spine w/o contrast. Indication: Lower back pain. Comparison: None. Findings: Prominent leftward curvature of the thoracolumbar spine, apex at the L2-3 level, Cobb angle 32 degrees. Lumbar lordotic curvature and alignment are presented. Vertebral body heights are normal with no fracture or compression deformity. Bone marrow signal is appropriate throughout. Diffuse disc desiccation, moderate disc height loss and Schmorl's nodes with endplate changes and anterior spondylotic changes. The conus terminates at the level of L1. No evidence of nerve root clumping or tethering. Paraspinal musculature is symmetric. Impression: Prominent leftward curvature of the thoracolumbar spine with advanced discogenic and facet degenerative changes of the lumbar spine resulting in multilevel central canal, lateral recess and bilateral foraminal stenoses as above. Grade 1 anterolisthesis at L4-5. Prominent disc herniations at T11-12 and T12-L1 are seen on the sagittal series.

XXXX – Physician Notes- XXXX.: Patient returns to clinic today for a follow up for lower back pain radiating down bilateral legs. Pt states that XXXX pain is a level 9/10. XXXX is here today to go over MRI results of the lumbar and is requesting an injection in XXXX right knee. HPI: -Pain: sharp, stabbing, aching, burning, shooting; -Severity: Severe 9 of 10; -Location: Lower back and bilateral leg; -Frequency: Constant; -Triggers: When standing, when stressed, while walking, with any activity, sitting, bending, going up and down stairs; -Modifying Factors: Improves: Stopping activity, with lying down, with pain medication, with rest; -Associated Signs and Symptoms: Fatigues, stiffness and weakness; -Previous Therapies: SCS explant: Blocks-Pain relief was moderate. Problems: Sprain of ligaments of

lumbar spine, initial encounter; Status: Active, onset: XXXX. Medications: Changed Meds: **XXXX** capsule 1 by mouth once a day x 30 days Start date: XXXX; XXXX capsule 1 by mouth 3 times a day x 30 days Start date: XXXX; XXXX tablet 2 tablets by mouth 3 times a day as needed for pain x 30 days Start date: XXXX. Discontinued Meds: XXXX x 30 days, Start date: XXXX, Stop date: XXXX (Completion of therapy); XXXX weekly all at the same time x 28 days Start date: XXXX, Stop date: XXXX (Completion of therapy); XXXX capsule, XXXX twelve H x 7 days, Start date: XXXX, Stop date: XXXX (Completion of therapy); XXXX (bulk) powder- use 17g dissolved in water once a day as directed x 30 days, Start date: XXXX, Stop date: XXXX (Completion of therapy). Plan Note: XXXX chronic axial low back pain with radiculopathy and myofascial component, s/p T1-S1 spinal fusion, significant deconditioning, muscle imbalance. Pt had early XXXX SCS implanted and removed due to infection. –Reviewed MRI of the lumbar spine in office today. Findings of the lumbar MRI shows L1-2 severe left curvature with disc bulge and severe left foraminal stenosis, L2-3 severe left ward curvature 2mm disc bulge, L3-4 2mm disc bulge central canal stenosis, L4-5 5mm anterolisthesis, L5-S1 disc bulge with moderate bilateral foraminal stenosis. –Schedule for bilateral L4-5, L5-S1 TF ESI x 3 for lumbar radiculopathy. Risks and benefits were advised as well as how to prepare for this procedure, patient agrees and wished to proceed. –Patient currently stable on current meds, refills were given today. Pt reports that the use of XX allows 50% improvement in performance of ADLs. Denies side effects common to their use. –Refill XXXX; to address acute exacerbations of chronic pain. –Refill XXXX w/4 refills; to address the radicular and neuropathic component of pain. –Refill XXXX w/4 refills; to address the axial and myofascial component of pain. –Continue XXXX bottle; XXXX. –Previous XXXX collected XXXX and consistent with medication. –Return to clinic in 2 weeks post injections. ***Patient reports the medication helps and is able to do ADLs. Denies aberrant behavior. Denies side effects. Denies sedation/drowsiness/respiratory depression/constipation. Pt extensively counseled regarding appropriate narcotic use. Informed and discussed with pt the risks of the medications which can include sedation/drowsiness/respiratory depression/constipation/sleep problems/addiction/low testosterone/liver toxicity. Pt understands and wishes to continue. Answered all patient's concerns and questions. Educated pt on the risks/side effects of the medications. Pt agrees to proceed.

XXXX – URA Determination- XXXX.: XXXX is certified by the XXXX under URA XX. The use of the word you within this document shall mean the injured employee, employee representative, or the employee's providers. XXXX has been asked to review the treatment request listed below for the medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor made the following determination: Services Requested: Lumbar transform bilateral L4-5, Lumbar Addt'l level bilateral L5-S1, Epidurography, Radiology, Anesthesia, Dexlido M Kit (64483, 64484, 72275, 72020, 01936, J3490). Determination: Non-certified. Diagnosis/Description: S33.5XXA-Sprain of ligaments of lumbar spine, initial encounter. Claim Dispute Language: The insurance carrier is disputing chiropractic care after XXXX, incontinence condition, diabetes and previous hysterectomy. Per the PLN11s dated XXXX, the insurance carrier is disputing the following as unrelated to the compensable injury: thoracic spine, cervical spine, unspecified reflex sympathetic dystrophy, unspecified disease of the spinal cord, current clinical symptoms (including but not limited to low back pain, fatigue, stiffness, tenderness, limited activity and antalgic gait). Clinical Rationale of Non-certification: Regarding L4/5 and L5/S1, ODG notes that radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented to support an ESI. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. While there is note of radiating pain on exam, there is no indication of altered sensation or motor in a dermatomal pattern. MRI notes stenosis but no nerve root compression. Criteria is not met. Recommend non-certification.

XXXX – URA Re-Determination- XXXX.: XXXX is certified by the XXXX under XX. The use of the word you within this document shall mean the injured employee, employee representative, or the employee's providers. XXXX has been asked to review the treatment request listed below for the medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor made the following determination: Services Requested: Lumbar transform bilateral

L4-5, Lumbar Addt'l level bilateral L5-S1, Epidurography, Radiology, Anesthesia, Dexlido M Kit (64483, 64484, 72275, 72020, 01936, J3490). Determination: Non-certified. Diagnosis/Description: S33.5XXA-Sprain of ligaments of lumbar spine, initial encounter. Claim Dispute Language: The insurance carrier is disputing chiropractic care after XXXX, incontinence condition, diabetes and previous hysterectomy. Per the PLN11s dated XXXX, the insurance carrier is disputing the following as unrelated to the compensable injury: thoracic spine, cervical spine, unspecified reflex sympathetic dystrophy, unspecified disease of the spinal cord, current clinical symptoms (including but not limited to low back pain, fatigue, stiffness, tenderness, limited activity and antalgic gait). Clinical Summary: Date of injury: XXXX. Date of service: XXXX: Patient presents with low back pain, radiating to bilateral lower extremity, rated 9 out of 10. Exam: Reflexes 2 out of 4. There is a request for epidural steroid injection. This request was prior denied due to lack of corroborating radiculopathy. The provider is now appealing, but no additional information has been provided. Decision: Upheld. Clinical Rationale: In this case, the claimant has complaints of lower back pain radiating into the lower extremity, and the provider is requesting a lumbar epidural steroid injection. No objective evidence of radiculopathy on the physical examination and corroboration by imaging studies showing a distinct nerve root compression. The claimant's physical examination does not document gross motor weakness, sensory loss, diminished reflexes and myotomal or dermatomal findings consistent with the requested level of injection. The request for lumbar epidural steroid injection is not medically necessary at this time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for lumbar epidural steroid injections (ESI) at L4-5, L5-S1 is denied. It is found to be not medically necessary.

The patient is a **XXXX** with lower back pain, radiating to both of XXXX legs. XXXX has had a spinal cord stimulator, which was removed due to infection. XXXX recent MRI demonstrates lumbar scoliosis with diffuse degenerative disc disease. XXXX has a grade I anterolisthesis at L4-5. A disc bulge is identified at L5-S1, associated with moderate foraminal stenosis. The treating physician has recommended ESI at L4-5 and L5-S1.

The Official Disability Guidelines (ODG) supports epidural steroid injections in patients with radiculopathy associated with a herniated disc, not spinal stenosis. Examination findings consistent with radiculopathy should correlate with imaging studies and/or electrodiagnostic testing.

This patient has diffuse degenerative disc disease in the lumbar spine. XXXX physical examination does not correlate with radiculopathy associated with a specific herniated disc. XXXX primary source of pain is not clearly defined in the records reviewed. XXXX does not meet criteria for a lumbar ESI.

Per ODG:

XX

ODG Criteria

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)**