



Notice of Independent Review Decision

DATE OF REVIEW: 4/14/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for caudal steroid injection.

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

A Texas licensed anesthesiologist.

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 or not medical necessity exists for each of the health care services in dispute.

The previously denied request for caudal steroid injection.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Letter dated 4/4/08.
- Note dated 4/4/08.
- Notice of Assignment of Independent Review Organization dated 4/3/08.

- **Company Request for Independent Review Organization dated 4/3/08.**
- **Notice of Case Assignment dated 4/3/08.**
- **Fax Cover Sheet/Comments dated 4/3/08, 4/2/08, 2/29/08, 2/19/08.**
- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/3/08.**
- **Request Form Request for a Review by an Independent Review Organization dated 4/2/08.**
- **Caudal Injections Procedure Authorization Request dated 2/19/08.**
- **Letter/Notice of Utilization Review Findings dated 3/7/08, 2/25/08.**
- **Cover Page (unspecified date).**
- **Consultation Report dated 12/10/07.**
- **Follow-Up Visit Report dated 10/6/07.**
- **Appeal Reconsideration Request dated 2/29/08.**
- **Procedure Note dated 2/11/08, 12/17/07.**
- **Pre-Injection Visit Report dated 2/11/08.**
- **Patient Pain Follow-up Questionnaire dated 2/11/08.**
- **Fax Cover Sheet/Epidural Steroid Procedure Referral Form dated 11/13/07, 11/12/07.**
- **Notice of Disputed Issue(s) and Refusal to Pay Benefits dated 9/24/07.**
- **Employer's First Report of Injury or Illness.**
- **Lumbar Spine with Bending Views X-Ray dated 2/19/07.**
- **Lumbar Spine X-Ray dated 1/25/07.**
- **Lumbar Spine MRI dated 2/6/07.**
- **Functional Capacity Evaluation Report dated 6/19/07.**
- **Electromyogram and Nerve Conduction Studies Report dated 9/10/07.**
- **Lumbar Spine Myelogram and CT Scan dated 2/28/08.**
- **Physical Medicine and Rehabilitation Follow-Up Visit Report dated 4/19/07, 3/22/07, 2/16/07.**
- **Physical Therapy Progress Report dated 3/14/07, 3/12/07, 3/9/07, 3/7/07, 3/5/07, 3/2/07, 3/1/07, 2/28/07, 2/23/07, 2/21/07.**
- **Examination Report dated 6/18/07, 5/21/07, 5/16/07, 2/27/07, 2/20/07, 2/14/07, 2/8/07, 1/25/07.**
- **History and Physical Report dated 1/24/07.**
- **Patient's Medications/Dosages List (unspecified date).**
- **Anesthesia Record dated 12/17/07.**
- **Contractual Lien and Authorization Form dated 12/17/07.**
- **Assignment of Benefits (unspecified date).**
- **Insurance Protocol dated 12/17/07.**
- **Consent Form for Treatment dated 12/17/07.**
- **Letter of Medical Necessity dated 12/17/07.**
- **Disclosure and Consent dated 12/17/07.**
- **Authorization Form to Treat and Assignment dated 12/17/07.**
- **Recovery Room Notes dated 12/17/07.**
- **Post Anesthesia Recovery Record dated 12/17/07.**

- Procedure Note dated 2/11/08, 12/17/07.
- Consultation Report dated 12/10/07.
- Pre-injection Visit dated 2/11/08.
- History/Physical/Neurological Examination Report dated 1/28/08.
- Physical Therapy Evaluation Report dated 9/25/07.
- Individual Psychotherapy Note dated 3/14/08, 1/17/08, 11/9/07, 11/7/07, 10/24/07, (unspecified date).
- Initial Behavioral Medicine Consultation Report/Addendum dated 9/10/07.
- Follow-up Visit Report dated 3/20/08, 2/16/08, 1/19/08, 12/8/07, 11/12/07, 9/15/07, 10/6/07.
- Physical Therapy Progress Report dated 10/18/07, 10/16/07.
- Patient Activity Flow Sheet dated 10/18/07, 10/16/07.
- Physical Therapy Daily Progress dated 10/18/07.
- Treatment Summary/Re-Assessment Note dated 3/14/08, 11/9/07.
- History and Physical Examination for Work Hardening dated 3/17/08.
- Report of Medical Evaluation dated 6/19/07.
- Designated Doctor Assessment dated 6/23/07.
- Clarification Request Correspondence dated 7/16/07.
- Impairment Rating Opinion Report/Letter dated 7/9/07.

No Guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Fell while restraining a detainee.

Diagnosis: Spondylolisthesis and disc bulge at L5-S1 with radiculopathy.

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

According to documentation provided for review, this male sustained an industrial injury, when he fell while restraining a detainee. The patient's diagnosis is spondylolisthesis and disc bulge at the L5/S1 level with L5 radiculopathy. He was initially treated with conservative care, including 9 visits of physical therapy and medications. He underwent an MRI in February 2007 which showed a disc herniation with severe right and moderate left foraminal narrowing. An electromyogram (EMG) was performed on 9/10/07 and showed evidence of L5 radiculopathy. The patient completed additional physical therapy as well as psychotherapy visits in September 2007 which did not improve his condition. The patient underwent caudal epidural steroid injection (ESI) on 12/17/07 and received 2-3 weeks of relief after the injection. The patient then underwent a repeat caudal ESI on 2/11/08. The progress note dated 3/20/08 indicated that the patient did not receive lasting

relief from the second ESI. The patient's current complaint is of pain in the back and right leg rated 6-7/10 in intensity, with numbness and tingling in the right lower extremity. Per the Official Disability Guidelines (ODG): "Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. 4) At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. ... To be considered successful after this initial use of a block/blocks, there should be documentation of at least 50-70% relief of pain from baseline and evidence of improved function for at least six to eight weeks after delivery. (7) In the therapeutic phase (the phase after the initial block/blocks were given and found to produce pain relief), repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." In this case, there is no documentation that the patient received 50-70% pain relief for 6-8 weeks after the ESI. The note of 3/20/08 (5.5 weeks after ESI #2) indicated that the patient's pain was back to baseline. Therefore, in accordance with the ODG, the recommendation will be for an adverse determination.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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. Official Disability Guidelines (ODG), Treatment Index, 6th Edition (web), 2008, Low back— Epidural steroid injections (ESIs), therapeutic
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).