



Notice of Independent Review Decision

DATE OF REVIEW: 10/27/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for caudal epidural steroid injection (ESI) under fluoroscopy with monitored anesthesia care (MAC) anesthesia.

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

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 ESI under fluoroscopy with MAC anesthesia.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Fax Cover Sheet dated 10/22/08.

- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 10/22/08.
- Notice to CompPartners. Inc of Case Assignment Sheet dated 10/22/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) Sheet dated 10/21/08.
- Review Summary dated 10/20/08.
- Full History & Physical Exam Sheet dated 10/14/08.
- Preauthorization Sheet dated 10/8/08, 8/20/08.
- Request for a Review by an Independent review Organization Sheet dated 10/8/08.
- Independent Review Organization Medical Dispute Resolution on an Appeal for a Caudal Epidural Steroid Injection Note dated 9/26/08.
- Notification of Determination dated 8/1/08.
- Preauthorization Request dated 6/25/08.
- Follow-Up Note dated 6/24/08.
- Motor Nerve study/Sensory Nerve Results dated 2/18/08.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Bending type of injury.

Diagnosis: Postlaminectomy syndrome and lumbar radiculopathy.

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

The claimant is a male who sustained a work-related injury on xx/xx/xx, involving the lumbar spine secondary to a bending over type mechanism. The current diagnoses are postlaminectomy syndrome and lumbar radiculopathy (subjective). From the information submitted, this claimant had undergone four lumbar spine surgeries, the last being performed in 2007. The claimant had lumbar epidural steroid injections prior to the spine surgeries, which resulted, of course, in an unsustained relief. Currently, the claimant is complaining of weakness in the lower extremities and decreased sensation in the lower extremities, with positive straight leg raise. From the progress note dated July 3, 2008, the claimant had low back pain radiating to the right lower extremity. The electromyogram/nerve conduction study (EMG/NCS) performed in February 2008, did not reveal any positive findings pertaining to the right lower extremity. This finding was noted in the "To Whom It May Concern" correspondence dated June 24, 2008. The current medication management consists of Neurontin, Darvocet, and Prilosec p.r.n. Of note, this claimant's prior history concerning correlating clinical examination pertaining to the lower extremities was unclear to this reviewer. After

review of the information submitted, the previous non-authorization for caudal epidural steroid injection has been upheld due to lack of available relevant clinical information in support of the application, particularly, no information regarding the presence of significant objective radiculopathy existing on the follow-up note submitted, although the claimant seemed to have subjective symptoms indicative of radiculitis.

The Official Disability Guidelines clearly state radiculopathy must be documented. Objective findings on examination need to be present. Unequivocal evidence of radiculopathy should be corroborative by EMG study and/or electrodiagnostic testing. There was no current radiography imaging study report of lumbar MRI available for review. The EMG/nerve conduction study of the lower extremities was negative for right lower extremity radiculopathy. Therefore, in accordance with the Official Disability Guidelines, recommendation is 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, Treatment Index, 6th Edition (web), 2008, Low back-Epidural injections.

- 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).