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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 02/08/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ESI under fluoroscopy

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

Board Certified in Orthopedic Surgery

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.

ESI under fluoroscopy - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the sacrum/coccyx interpreted by M.D. dated 12/17/08
Evaluations with M.D. dated 05/11/09, 06/15/09, 08/03/09, 08/31/09, 10/05/09, and 11/09/09
DWC-73 forms from Dr. dated 08/03/09, 08/31/09, and 10/05/09
A letter of recommendation from, Inc. dated 08/11/09
An evaluation with, M.D. dated 08/21/09
Designated Doctor Evaluations with M.D. dated 09/09/09, 10/26/09, and 12/22/09
A DWC-73 form from Dr. dated 09/09/09, 10/26/09, and 12/22/09
An evaluation with M.D. dated 10/22/09
A treatment planning evaluation with Dr. L.P.C., and, P.T. dated 10/22/09
A DWC-73 form from M.D. dated 11/09/09
An evaluation with an unknown provider (signature was illegible) dated 11/12/09
A DWC-73 form from D.O. dated 11/12/09
A physical therapy evaluation with P.T. dated 12/02/09
Evaluations with M.D. dated 12/02/09, 12/03/09, 12/16/09, and 01/14/10
A Quantitative Functional Capacity Evaluation (FCE) dated 12/03/09
A DWC-73 form from Dr. dated 12/03/09
A request for approval of a chronic pain management program from Dr. dated 12/07/09
Evaluations with M.D. dated 12/11/09, 12/18/09, 01/15/10,
A request for approval of an epidural steroid injection (ESI) from Dr. dated 12/14/09
A letter of non-authorization, according to the Official Disability Guidelines (ODG), from M.D. dated 12/18/09
A request for approval of an ESI from Dr. dated 12/30/09
Chronic pain management dated 01/05/10 and 01/08/10
A letter of non-authorization, according to the ODG, from, M.D. dated 01/20/10
A letter from dated 01/28/10
An undated letter "To Whom It May Concern" from the patient
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

An MRI of the sacrum/coccyx interpreted by Dr. on 12/17/08 showed a left posterior paramedian broad based protrusion/herniation with T2 high signal fissuring and slight contact of the left S1 nerve root. On 05/11/09, Dr. performed trigger point injections. On 06/15/09, Dr. recommended an FCE, a TENS unit, and a second opinion evaluation. On 08/03/09, Dr. recommended a work conditioning program. On 08/31/09, Dr. recommended a Medrol Dosepak and continuation of a work conditioning program. On 09/09/09, Dr. felt the patient was not at Maximum Medical Improvement (MMI). On 10/26/09, Dr. felt the patient was at MMI as of 09/09/09 with a 5% whole person impairment rating. On 11/09/09, Dr. recommended MRIs of the lumbar spine and right shoulder. A Quantitative FCE on 12/03/09 indicated the patient would benefit from an interdisciplinary rehabilitation program. On 12/07/09, Dr.

requested approval for a chronic pain management program. On 12/11/09, Dr. felt the patient was a good candidate for a caudal ESI. On 12/16/09, Dr. noted the patient had reduced her Darvocet-N and had discontinued her Doxepin at night in favor of Lunesta. On 12/18/09, Dr. wrote a reconsideration letter for the ESI. On 12/18/09, Dr. wrote a letter of non-authorization for the ESI. Chronic pain management was performed on 01/05/10 and 01/08/10. On 01/15/10, Dr. wrote another letter requesting the ESI. On 01/20/10, Dr. wrote a letter of non-authorization for the ESI.

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

The rationale for performing an ESI under fluoroscopy is not present. The ODG does endorse the use of ESIs in cases with clear evidence of radiculopathy. There is no clear evidence of radiculopathy. Decreased sphincter tone has been mentioned, but this has not been mentioned on the physical examination. Further, there has been no evidence of radiculopathy. A decreased rectal tone would not necessarily be evidence of radiculopathy. Furthermore, motor weakness would not be treated by an ESI. Lastly, coccydynia does not respond to ESIs and is not one of the diagnosis for which an ESI would be expected. Last, there was no evidence of neuroforaminal narrowing or compression lesion in the sacrum as far as the MRI of the pelvis/sacrum was able to show. I do not believe an ESI would be the appropriate treatment for this patient and not justified and cannot be approved if one is consistent with the ODG. Therefore, the requested ESI under fluoroscopy would not be reasonable or necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE
- 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)