COMPPARTNERS

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Notice of Independent Review Decision

DATE OF REVIEW: **12/22/09**

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for 1 bilateral caudal block at levels L4-5 and L5-S1.

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

Texas licensed pain management specialist and anesthesiologist.

REVIEW OUTCOME:

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

□ Upheld (Agree)

x 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 1 bilateral caudal block at levels L4-5 and L5-S1.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Patient Letter dated 12/21/09.
- Notice of Utilization Review Findings dated 12/17/09.
- Lawyer's Letter dated 12/15/09.

- Doctors Report dated, 9/18/09.
- Physician Advisor Review dated 11/5/09, 9/18/09.
- Follow Up Consultation dated 10/13/09, 8/18/09, 5/15/09, 3/20/09, 1/6/09, 10/14/08, 3/24/08, 11/13/07.
- Operative Report dated 4/13/09, 12/8/08, 5/3/07, 3/8/07.
- Anesthesia Record dated 4/13/09, 12/8/08, 5/3/07, 3/8/07.
- Discharge Instructions dated 12/8/08.
- Intraoperative Record dated 12/8/08.
- Post Anesthesia Care Unit Report dated 12/8/08.
- Follow Up Note dated 3/14/07, 3/20/07, 2/13/07.
- Reexamination Report dated 6/17/08.
- IME dated 11/14/06.
- Notification Letter dated 12/10/96.
- Consultation Report dated 1/9/94.
- Narrative Report dated 8/20/95.
- Update Letter dated 7/16/94.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):
Age: xx
Gender: Female
Date of Injury: xx/xx/xx
Mechanism of Injury: Fall

Diagnosis: Spondylolisthesis

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

This female had a history of low back pain since sustaining an injury on xx/xx/xx. The mechanism of injury was a fall. The diagnosis was spondylolisthesis. According to the multiple medical notes reviewed, the low back pain radiated into the left lower extremity. The pain was a 10 on a 0-10 scale. The patient was in a wheelchair. On physical exam, there was decreased range of motion in the lumbar region with tenderness. There was hypesthesia of the lower extremity, left greater than the right. Straight leg test was positive on the left. An MRI showed a herniated disc at L5-S1. According to the 05-15-09 medical note, the patient had previous ESIs, on 04-13-09 and 12-28-08, with 70 % pain relief. The pain level went from a 10 to a 3 after the ESI and the patient had better function with less medication requirement. She was on Ultram and Vicodin. The request is now for bilateral caudal block at levels L4-5 and L5-S1, which is a repeat ESI. The ODG state the following, "(7) Therapeutic phase: If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be required. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of symptoms. The general

consensus recommendation is for no more than 4 blocks per region per year. (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response." This patient meets the above criteria for a repeat ESI. Therefore, the request is certified.

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.

x ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines (ODG), Treatment Index, 7th Edition (web), 2009, Low back—Epidural steroid injections (ESIs), diagnostic.

□ 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).