



Notice of Independent Review Decision

DATE OF REVIEW: 12/21/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Caudal ESI through a Catheter Under Fluoroscopy w/ I.V. Sedation

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

Board Certified in Physical Medicine & Rehabilitation

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.

Lumbar Caudal ESI through a Catheter Under Fluoroscopy w/ I.V. Sedation - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Pump Refill Procedure, M.D., 06/11/07
- Initial Pain Evaluation, D.O., 10/25/07

- Follow Up, Dr. 05/09/08, 07/28/08, 01/05/09, 03/23/09, 06/15/09, 09/15/09, 10/13/09, 11/20/09
- Operative Report, Dr. 08/05/08
- Progress Notes, D.C., 05/28/09, 06/08/09, 06/24/09, 07/09/09, 07/20/09, 08/17/09, 08/28/09, 09/11/09, 09/16/09, 09/17/09, 10/12/09, 10/29/09, 11/13/09
- Statement of Pharmacy Services, Dr. 06/25/09, 07/29/09, 09/16/09, 10/30/09
- Statement of Pharmacy Services, Dr. 06/26/09, 08/25/09, 09/17/09, 10/22/09, 11/18/09
- Pre-Authorization, Dr. 09/22/09, 10/22/09, 11/04/09
- Denial Letter, 09/25/09, 11/12/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured when he exited a car and fell. He underwent numerous back treatments, including open back surgery three times. He had been treated for post-lumbar laminectomy pain syndrome. He had required increasing doses of narcotic analgesic both intrathecally and orally. He was finally titrated off oral narcotic medication and was treated for possible psychosis and manic depression at one time. He had a 40 cc SynchroMed pump implanted with 10,000 mcg/ml of Fentanyl. Along with the pump, he was also treated with Trazodone and Hydrocodone.

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

Based upon the records available for review, the medical necessity for treatment in the form of a lumbar caudal epidural steroid injection through a catheter under fluoroscopy with intravenous sedation is currently not established as a medical necessity per criteria set forth by the Official Disability Guidelines.

The records available for review document that there was a chronic history of low back pain. The records available do document that over the years, treatment has included access to an attempt at a lumbar epidural steroid injection. The records available for review do not provide specifics with respect to how much benefit was obtained from a previous attempt at such a procedure. Given the fact that multiple surgical procedures have been provided to the lumbar spine region in the past, one must question if, indeed, there has been a significantly positive response in the past to treatment in the form of a lumbar epidural steroid injection. Additionally, the records available for review do indicate that in the past, consideration was given for treatment in the form of a lumbar epidural steroid injection for treatment of axial low back pain. The Official Disability Guidelines do not support a medical necessity for treatment of axial low back pain in the form of a lumbar epidural steroid injection. The records available for review do not provide any documentation to indicate that there has been a recent diagnostic study accomplished in the past in the form of a radiographic study or an electrodiagnostic assessment, which would assist in substantiating the medical diagnosis of an acute

lumbar radiculopathy. Additionally, the Official Disability Guidelines do not typically support that there should be a need for utilization of sedation with respect to medical treatment in the form of a lumbar epidural steroid injection. Hence, per criteria set forth by the Official Disability Guidelines and based upon the records available for review, at the present time, medical necessity for treatment in the form of a caudal lumbar epidural steroid injection with sedation would not appear to be of medical necessity.

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)