

C-IRO Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199A
Austin, TX 78726
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L5-S1 Lumbar Transforaminal Epidural Steroid Injection

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

MD, Board Certified Neurosurgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRI lumbar spine 02/26/08

Clinic note Dr. dated 12/12/08

MRI lumbar spine without contrast dated 03/25/09

Radiographic report lumbar spine two views dated 03/25/09

Medical records reviewed dated 09/06/10

Facsimile transmittal sheet dated 11/16/10

Utilization review request left L5-S1 lumbar transforaminal epidural steroid injection Dr. dated 02/01/11

Utilization review adverse determination request left L5-S1 lumbar transforaminal epidural steroid injection Dr. dated 02/21/11

Official Disability Guidelines and Treatment Guidelines

Pain Consultants 1/24/08 to 2/24/11

Surgery Center 4/16/08 to 5/20/08

Imaging 3/25/09

Diagnostic Imaging 2/26/08

Associates PC 8/26/10 to 11/16/10

Restat 2/2/11

Neurosurgery Center, P.A. 12/12/08

Review Experts, P.A. 9/6/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped at work and hit a chair. The patient presented on 01/24/08 with complaints of back pain that is improving only minimally with physical therapy. Impression is lumbar sprain, spasm of muscle and lumbago. MRI of the lumbar spine dated 02/26/08 revealed L5-S1 central disc protrusion measuring approximately 8 mm that slightly effaces the anterior thecal sac; there

is no significant canal stenosis or neural foraminal narrowing. The patient underwent caudal epidural steroid injection on 04/16/08. Follow up note dated 05/01/08 indicates that the patient was seen in the ER for bowel incontinence. The patient reports that the epidural steroid injection "did not help her pain very much". Follow up note dated 05/05/08 indicates that the patient will start water therapy and no further injections are anticipated. The patient underwent second caudal epidural steroid injection on 05/20/08. Follow up note dated 06/02/08 reports "no radicular symptoms." Steroid injections "were unsuccessful." The patient is leaning towards surgery. Follow up note dated 06/16/08 reports that the patient has undergone two ESIs "neither of which were helpful to her for her pain symptoms." The patient continued to be seen by Dr. who continued to recommend surgical intervention.

Follow up note dated 11/19/08 reports that surgery was approved and performed on 10/29/08. Postoperative note dated 01/05/09 indicates that the patient is having persistent pain in the left upper thigh with paresthesias. The note states that the patient should be more improved than she is right now. Note dated 02/19/09 indicates that the patient has started physical therapy and will be continuing for next 6 weeks. Lumbar radiographs dated 03/25/09 reveal minimal degenerative changes in the facet joints. Lumbar MRI dated 03/25/09 revealed minimal degenerative changes within the facet joints at L4-5 and L5-S1 without narrowing of the central spinal canal and neural foramina. Note dated 03/25/09 indicates that the patient has completed 3 weeks of physical therapy. Note dated 05/26/09 indicates that patient is to start pain management program for the next 8 weeks. She is noted to likely be progressing very slowly because therapy was not started until 3 months postoperatively.

Note dated 06/18/09 indicates that Dr. is recommended epidural steroid injection. Note dated 07/20/09 indicates that the patient has essentially plateaued. Dr. subsequently recommends discogram with repeat surgery to remove extensive scar tissue that has formed since surgery. Note dated 01/04/10 indicates that the patient has no objective neurological findings, but obvious restricted movements of lumbar spine. Follow up note dated 05/11/10 indicates that Dr. is requesting another epidural steroid injection since surgery is still not being approved. The patient is at statutory MMI and has a permanent 5% impairment.

The patient underwent transforaminal epidural steroid injection at left L5-S1 on 06/14/10. Follow up note dated 06/29/10 indicates that the patient is 50% improved overall, but still has severe pain. Follow up note dated 07/12/10 indicates that the patient has ongoing low back and left lower extremity pain. Note dated 08/16/10 indicates that the patient's need for medication has not changed. Evaluation dated 08/26/10 indicates that the patient has completed 6 sessions of individual psychotherapy.

Peer review dated 09/06/10 indicates that it was not until after the ESI was denied that Dr. discovered "numbness and tingling" into the right lower extremity, theretofore not reported and in no particular nerve root distribution. The peer reviewer notes that ESIs were again denied on 07/01/10. The patient underwent transforaminal epidural steroid injection on the left at L5-S1 on 09/16/10. Follow up note dated 09/28/10 indicates that the patient's leg pain resolved after the second injection, now mainly back pain most likely facet related; epidural steroid injection did not help back pain much.

The patient subsequently underwent paravertebral facet joint injection on the left at L4-5 on 12/21/10. Note dated 01/10/11 indicates that facet injection helped with low back pain, but now left lower extremity pain returned. Office visit note dated 02/08/11 indicates that the patient "did have two more ESI injections since last office visit with minimal improvement". Physical examination on 02/24/11 notes gait and station are normal. There is tenderness off midline bilaterally in a symmetrical distribution in the paraspinous muscles. Flexion and extension of the lumbar spine are restricted. Muscle strength is rated as 5/5 in the bilateral lower extremities with the exception of 4/5 left EHL. Muscle tone and size is normal and symmetrical in all 4 extremities. Sensory exam reveals hypoesthesia in L5 distribution. Straight leg raising is positive on the left.

Initial request for left L5-S1 lumbar transforaminal epidural steroid injection was non-certified on 02/01/11 noting that the patient underwent two prior epidural steroid injections with 50%

relief of pain. There is no clinical documentation provided regarding functional improvement or decrease in pain medications. The denial was upheld on 02/21/11 noting that the need for pain medications had increased. The patient reported 50% relief from epidural steroid injection in June 2010. MRI does not document the presence of neural foraminal stenosis at L5-S1.

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

Based on the information provided, the reviewer finds that Left L5-S1 Lumbar Transforaminal Epidural Steroid Injection is not medically necessary at this time. The patient underwent two previous epidural steroid injections on 06/14/10 and 09/16/10; however, there is no comprehensive assessment of the patient's objective, functional response to these injections. The patient reported 50% relief two weeks after the initial injection. The patient's need for medication was reported as unchanged in August 2010 and had actually increased per medical records dated February 2011. The patient's MRI does not support a diagnosis of radiculopathy. Given the current clinical data, the request for Left L5-S1 Lumbar Transforaminal Epidural Steroid Injection has not met the criteria for ESI in ODG. Based on the information provided, the reviewer finds that Left L5-S1 Lumbar Transforaminal Epidural Steroid Injection is not medically necessary at this time.

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

ACOEM-AMERICA 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)