

SENT VIA EMAIL OR FAX ON
Sep/16/2011

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Sep/16/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
One (1) outpatient lumbar epidural steroid injection (ESI) under fluoroscopy at right L5/S1

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic spine surgeon, practicing 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

OD Guidelines

1. Notice of utilization review findings 08/01/11 recommending non-authorization of outpatient lumbar epidural steroid injection under fluoro at right L5-S1
2. Notice of utilization review findings 08/04/11 recommending non-authorization of reconsideration request outpatient lumbar epidural steroid injection under fluoro at right L5-S1
3. Office notes Dr. 06/14/10 through 07/25/11
4. Radiology report x-rays three view lumbar spine 07/25/11 and 02/21/11
5. Physical therapy records (initial evaluation, progress summary and discharge summary) 02/24/11 through 04/06/11
6. Hospital records (history and physical, operative report, discharge summary) 01/12/11 through 01/14/11
7. Lumbar discogram and post CT 12/07/10
8. CT thoracic spine 12/07/10
9. CT myelogram lumbar spine 11/02/10

10. MRI lumbar spine 09/07/10
11. Radiology report five views lumbar spine 08/05/10

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male who was injured on xx/xx/xx when he was clearing tree limbs and was struck on top of the head by a tree limb. He was not wearing a hard hat. He had onset of neck pain and aching pain in the shoulders and arms and low back pain with pain radiating down the right leg. On 01/12/11 the injured employee underwent L4-S1 decompressive laminectomy with L4-S1 anterior/posterior lumbar interbody fusion with internal bone growth stimulator. Follow up on 02/21/11 reported surgical incision is completely healed. The injured employee did not ask for any medication. He walked well. He has good strength in lower extremities. There is no radiating hip or leg pain. X-rays showed good position of all instrumentation except for a little posterior positioning of one of the L5-S1 cages. The injured employee was referred to physical therapy and to continue use of back brace. On 04/18/11 follow up noted the injured employee to be three months post L4-5 L5-S1 decompression fusion and instrumentation. X-rays showed normal alignment with no changes except progressive interbody and posterolateral fusion. There is no radiating hip or leg pain. There was some mild residual lumbar pain which he treats with occasional aspirin. He is increasing activities. Leg strength is good. Brace is now optional. On 07/25/11 the injured employee was noted to be six plus months after posterior L5-S1 decompression, fusion and instrumentation. He has some posterior positioning of the L5-S1 cages. He was noted to be doing very well with no back or hip or leg pain until about six weeks ago. He has not had any subsequent injury. He began having pain radiating down the lateral aspect of the right thigh just below the knee. He appears to be neurologically stable. He was prescribed Hydrocodone 10mg and Flexeril. A right L5-S1 epidural steroid injection was requested.

A utilization review performed on 08/01/11 recommended non-authorization of outpatient lumbar epidural steroid injection under fluoroscopy on the right at L5-S1. It was noted that the injured employee underwent L4-S1 lumbar fusion with internal bone growth stimulator on 01/12/11. Last office visit on 07/25/11 noted development of back and leg pain about six weeks ago. The reviewer noted there were no examination findings of dermatomal pain or decreased sensation and do not appear to be any post surgical recommendations, there is no sufficient documentation or rationale for outpatient lumbar epidural steroid injection.

A utilization review of a reconsideration request was performed on 08/04/11 and recommended non-authorization of outpatient lumbar epidural steroid injection under fluoroscopy on the right at L5-S1. It was noted that the injured employee had undergone multiple imaging studies including MRIs, x-rays and CT scans of the lumbar spine which were noted to show degenerative disc disease and bulging disc at L4-5 and L5-S1. The injured employee underwent L4-S1 ALIF/PLIF with internal bone growth stimulator. Following surgery the injured employee developed pain in the back and pain in the legs. X-rays disclosed there are posterior positioning of the cages at L5-S1 and half the disc spaces protruding beyond the posterior margin of the disc space. The injured employee was noted to appear "to be neurologically stable" without a neurologic examination being performed. It was noted that previous peer review clearly states the documentation fails to meet recommendations of Official Disability Guidelines for use of epidural steroid injections. The appeal documentation fails to meet criteria recommended by Official Disability Guidelines and fails to identify the injured employee's pain generators which are likely secondary to the extensive fusion of the lumbar spine and failed back surgery. The previous denial was upheld and non-authorization was recommended.

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

Based on the clinical information provided, the proposed outpatient lumbar epidural steroid injection under fluoroscopy at right L5-S1 is not indicated as medically necessary. The injured employee is noted to have sustained an injury on xx/xx/xx. He subsequently underwent lumbar decompression, fusion and instrumentation L4-S1 performed 01/12/11. Post-operatively the injured employee did well. However office visit notes dated 07/25/11

reported the injured employee developed back and leg pain about six weeks ago with pain radiating down the lateral aspect of the right thigh. He was reported to be neurologically stable. There are no post-operative imaging studies with objective evidence of neurocompressive pathology. There is no evidence of neurologic deficit on physical examination indicating motor or sensory changes in a specific myotomal or dermatomal distribution. There is no report of positive straight leg raise or other indications of radiculopathy. Per Official Disability Guidelines, radiculopathy must be documented with objective findings on examination and corroborated by imaging studies and/or electrodiagnostic testing. Given the current clinical data, medical necessity is not established for one outpatient lumbar epidural steroid injection under fluoroscopy on the right at L5-S1. The previous reviews correctly determined the request to be non-authorized and should be upheld on IRO.

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)