



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 09/23/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection, Single (not via indwelling catheter), Not Including Neurolytic Substances, With or Without Contrast (for either localization or epidurography), of Diagnostic or Therapeutic Substance(s)

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.

Injection, Single (not via indwelling catheter), Not Including Neurolytic Substances, With or Without Contrast (for either localization or epidurography), of Diagnostic or Therapeutic Substance(s) – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Operative Report, M.D., 11/04/08
- Office Note, Dr., 02/25/09, 07/29/09
- Report of Procedure, M.D., 09/25/09
- Office Visit, Dr., 11/16/10, 12/21/10, 01/30/11, 02/03/11, 02/17/11, 03/09/11, 04/13/11, 05/19/11, 05/31/11, 06/07/11, 06/14/11, 06/21/11, 07/12/11, 08/02/11, 08/24/11
- Office Evaluation, Dr., 05/05/11
- Lumbar Spine MRI, M.D., 06/07/11
- Operative Report, Dr., 07/13/11
- Pre-Authorization, 08/09/11, 09/02/11
- Denial Letter, 08/09/11, 09/06/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

In November 2008, the patient underwent a decompressive laminectomy of L4, bilateral L4-L5 lysis of epidural adhesions, right L4-L5 facet removal and left L4-L5 medial facetectomy and foraminotomy. In September, 2009, a Dilaudid trial was administered. From November 2010 through April 2011, the Dilaudid pump was refilled. During that time he was maintained on Ultram 50 mg, Baclofen 10 mg, Norco 10/325 mg, and Neurontin 300 mg. An epidural steroid injection (ESI) was performed on 02/17/11. From May 2011 through June 2011, the pump continued to be refilled. The claimant was then maintained on Lyrica and Norco. A lumbar spine MRI showed status post anterior and posterior fusions at L4-L5 and L5-S1 levels. Posterior instrumentation at L4-L5 resulted in some field distortion artifact. The fusions appeared solid anteriorly and posteriorly at L5-S1; however, the status of bone fusion at L4-L5 was indeterminate. At L3-L4, there was mild to moderate disc degeneration with Modic type 1 marrow degenerative changes. There was slight degenerative retrolisthesis of L3 on L4 with a 3-4 mm posterior broad-based disc pseudobulge/protrusion flattening the ventral thecal sac. The claimant continued with a pump refill in July 2011. Bilateral L3-L4 ESIs were performed on 07/13/11. A repeat procedure was recommended on 08/02/11.

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

The proposed injection, more commonly described as a caudal epidural steroid injection, is not medically reasonable or necessary. This is a patient who had a piloidal L3-L4 transforaminal epidural steroid injection with 50% relief times three days on 06/07/11. He has had multiple other treatment procedures, yet he has described worsening pain. The ODG criteria for approval of epidural steroid injection indicates that if a repeat injection is proposed, 50% to 70% relief over a period of six to eight weeks needs to be established. This has not been the case. Furthermore, it is required that evidence of radiculopathy be present on physical examination and corroborated by either MRI or

EMG evidence. There is very little examination documented in this case and specifically no documentation supportive of an actual radiculopathy on physical examination. Furthermore, an EMG was not performed, nor did the MRI corroborate evidence of radiculopathy. As such, the ODG criteria for epidural steroid injection cannot support this request as reasonable and necessary.

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)
- AMA GUIDES 5TH EDITION