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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/30/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L4 and L5 Transforaminal ESI with Epidurogram, one injection as an outpatient

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

M.D., Board Certified Anesthesiology/Pain Management

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 medical necessity exists for each health care service in dispute. The reviewer finds medical necessity is not established for Right L4 and L5 Transforaminal ESI with Epidurogram, one injection as an outpatient.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Reconsideration request Dr. 07/09/12

Office notes Dr. 06/11/12

MRI lumbar spine 04/24/12

EMG/NCV lower extremities 05/31/12

Physical therapy progress note 04/12/12-05/08/12

Appeal letter 07/02/12

Preauthorization request first request 06/11/12

Notice of denial of preauthorization 06/14/12

Notice of reconsideration 06/25/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female whose date of injury is xx/xx/xx. She suffered a back injury while performing burn care on a patient. She complains of low back pain that radiates to bilateral buttock, right groin, bilateral posterior thighs and anterior thigh, right calf and right foot. MRI of lumbar spine dated 04/24/12 revealed congenital canal narrowing beginning at L2-3 through L4-5, showing increased tapering caudally. There is mild canal stenosis seen at L5-S1. No herniated nucleus pulposus is seen. There is mild foraminal encroachment on left at L4-5, with minimal foraminal encroachment on right at L3-4 and L4-5. No vertebral body compression fracture was seen. There was minimal facet arthropathy noted at L2-3 and L5-S1. Electrodiagnostic testing performed 05/31/12 revealed no evidence of peripheral neuropathy, entrapment neuropathy, radiculopathy, or other neuromuscular disease of either leg. Records indicate the claimant was treated conservatively with narcotics, muscle relaxers, physical therapy, and oral NSAIDs without pain relief. She was noted to have gotten moderate relief with Medrol DosePak but not for substantial amount of time. Physical

examination on 06/11/12 noted the patient to be 5'3" tall and 195 lbs. Back exam revealed full active range of motion in all planes. Sensation was normal T12 through S5. Deep tendon reflexes were 2/4 at the bilateral knees and ankles. Muscle strength was 5/5 throughout the bilateral lower extremities. Kemp's was positive on the right and negative on the left. Left slump test was positive for radiculopathy, right slump test was positive for back pain and radiculopathy. Straight leg raise was positive on the right for back pain and radiculopathy, negative on the left. Faber and Gaenslen's were negative bilaterally. It was recommended that she undergo right L4 and L5 transforaminal epidural steroid injection with epidurogram.

A pre-authorization request for right L4 and L5 transforaminal epidural steroid injection with epidurogram, one injection as an outpatient was denied per utilization review determination dated 06/14/12 noting that the physical examination from 03/12 does not document evidence of clinical radiculopathy and no electrodiagnostic studies were provided indicating evidence of radiculopathy. There was no documentation of physical therapy and activity modification has not been provided in the records. A reconsideration request for right L4 and L5 transforaminal epidural steroid injection with epidurogram, one injection as an outpatient was denied per utilization review determination dated 06/25/12. It was noted previous denial was due to lack of objective physical examination findings of clinical radiculopathy and lack of exhaustion of lower levels of care such as physical therapy and activity modification prior to consideration of epidural steroid injections. No additional records were provided for review. Guidelines indicate there must be clinical findings of radiculopathy such as loss of sensation in a specific dermatomal pattern, loss of strength in a specific myotomal and loss of reflexes. The objective physical examination findings do not document any clinical evidence of lumbar radiculopathy. Records did not reflect significant neurocompression documented on MRI or radiculopathy confirmed on electrodiagnostic studies. As such the request is recommended for denial.

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

The claimant is noted to have sustained an injury to the low back on xx/xx/xx. MRI of the lumbar spine revealed mild canal stenosis at L5-S1 with no herniated nucleus pulposus seen and no evidence of nerve root compression. Electrodiagnostic testing of the bilateral lower extremities reported no evidence of radiculopathy. Clinical examination revealed no motor, sensory or reflex changes. Based on the medical records provided for review and the evidence-based guidelines, the reviewer finds medical necessity is not established for Right L4 and L5 Transforaminal ESI with Epidurogram, one injection as an outpatient.

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)