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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

Signed electronically on: October/29/2012

DATE NOTICE SENT TO ALL PARTIES: Oct/29/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Lumbar 3-4 Epidural steroid injection Intravenous sedation

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

M.D., Board Certified Orthopedic Surgeon, Spine Surgeon

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 the requested Right Lumbar 3-4 Epidural steroid injection Intravenous sedation is not indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Follow-up notes 01/26/10-09/12/12

Initial evaluation and progress notes 06/22/10-01/26/12

Functional capacity evaluation dated 10/06/10

Operative report dated 04/21/11

Utilization review determination 05/27/11

CT lumbar spine without contrast dated 06/02/11

CT lumbosacral spine without paramagnetic contrast dated 06/02/11

MRI lumbar spine without contrast dated 08/30/12

Script orders 08/31/12

Patient profile/injured worker's information no date

Medications report 08/31/12

Peer review report dated 09/11/12

Utilization review determination dated 09/12/12

Peer review report dated 09/26/12

Utilization review determination dated 09/28/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male. On this date the patient fell off a ladder. Note dated 04/13/10 indicates that the

patient is status post laminotomy at L5-S1 on the left and he has had an increase in symptoms since surgery. Note dated 06/15/10 indicates that the patient is seen in follow up of his revision decompression and fusion for recurrent disc herniation and persistent documented radiculopathy. Note dated 09/03/10 indicates that the patient's right thoracic pain is at least 80% better after local facet injections. Note dated 10/26/10 states that he has had about 10 sessions of work conditioning. Follow up note and report of impairment rating dated 11/17/10 indicates that the patient is ready to return to full duty. The patient was given 15% whole person impairment. The patient underwent right T6, T7 and T8 radiofrequency rhizotomy on 04/21/11 followed by 100% improvement, per follow up note dated 05/18/11. CT of the lumbar spine dated 06/02/11 revealed degenerative changes with spurring and sclerosis at L3-4. There is diffuse bulging of the annulus fibrosis with effacement of the thecal sac. There are hypertrophic degenerative changes in the facet joints with thickening of the ligamentum flavum. There is moderate spinal stenosis at this level. The patient subsequently underwent revision fusion at L5-S1 on 10/12/11. Office visit note dated 07/24/12 indicates that lumbar range of motion is normal. Straight leg raising is normal bilaterally. Lower extremity strength is symmetrically present. Lower extremity reflexes are symmetrically present and normal. Sensation is normal.

MRI of the lumbar spine dated 08/30/12 revealed disc desiccation with mild posterior diffuse disc bulging and marginal spurring as well as moderately prominent facet hypertrophy producing trefoil shaped narrowing of the spinal canal posterolaterally at L3-4. This appears without significant change from the previous CT exam dated 06/02/11. Inferior neural foraminal narrowing is present bilaterally due to disc bulge and marginal spur but no impingement on the exiting nerve root is seen. Office visit note dated 09/12/12 indicates that the patient is compliant with a home exercise program.

Initial request for right lumbar 3-4 epidural steroid injection intravenous sedation was non-certified on 09/12/12 noting that the claimant has chronic low back pain after multiple prior back surgeries. There was no reflex, motor or sensory change on exam. There were no objective signs of radiculopathy on exam that correlate with the imaging. The imaging shows no significant change since his CT scan in 2011. There was leg and back pain after recent strain injury to the back. There was a gap of six months since the last visit. There has been no recent attempt at physical therapy to try to avoid another injection. The denial was upheld on appeal dated 09/26/12 noting that there is no current, detailed physical examination submitted for review to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines. There is no documentation of extreme anxiety or needle phobia to support intravenous sedation.

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

The Official Disability Guidelines report that radiculopathy must be documented, and objective findings on examination need to be present. The patient's physical examination fails to establish the presence of active lumbar radiculopathy with normal lumbar range of motion, negative straight leg raising bilaterally, and intact sensation, motor testing and deep tendon reflexes in the lower extremities. There is no indication that the patient has undergone any recent active treatment. Additionally, the submitted records fail to document the presence of extreme anxiety or needle phobia to support intravenous sedation. The reviewer finds the requested Right Lumbar 3-4 Epidural steroid injection Intravenous sedation is not indicated as medically necessary.

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)