

C-IRO Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/16/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpatient lumbar transforaminal epidural steroid injection L4-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Anesthesiologist and 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. It is the opinion of the reviewer that the request for outpatient lumbar transforaminal epidural steroid injection L4-S1 is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 08/08/13, 08/20/13, 05/14/13, 04/01/13

IRO dated 02/03/10, 06/06/13

Lumbar MRI dated 07/18/08, 03/30/10

Radiographic report dated 09/15/08

EMG/NCV dated 09/26/08

Operative report dated 10/27/09, 02/08/11, 03/22/12, 04/26/12, 12/07/10, 07/26/12

Progress notes dated 04/09/12, 06/13/12, 03/13/13, 05/14/13, 08/05/13, 09/24/12, 02/20/12, 01/04/11, 11/18/11, 10/17/11, 06/22/11, 04/06/11, 03/01/11, 01/13/11, 10/19/10, 11/10/10, 08/25/10, 08/09/10

Telephone note dated 08/19/13, 05/17/13, 04/08/13, 10/30/12, 10/18/12

Office note dated 09/15/08, 11/25/08, 01/05/09, 10/08/09, 11/23/09, 12/17/09

Peer review dated 09/27/10

Prospective IRO review response dated 09/25/13

Letter dated 08/13/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. EMG/NCV dated 09/26/08 revealed no evidence of entrapment neuropathy or radiculopathy in the bilateral lower extremities. Note dated 11/25/08 indicates that the patient's pain level decreased from 7-8/10 to 3/10 after epidural steroid injection. Note dated 10/08/09 indicates that the patient has had physical therapy, chiropractic care and at least 3 epidural steroid injections which have given him no help. Lumbar MRI dated 03/30/10 revealed at L4-5 degenerative disc disease and broad based disc bulge. There is a small central disc protrusion. There is facet hypertrophy and ligamentum flavum thickening with

moderate deformity of the thecal sac; there is bilateral foraminal stenosis due to disc and facet disease. At L5-S1 there is degenerative disc disease with broad based disc bulge and central disc herniation. There is facet disease and ligamentum flavum thickening. No spinal stenosis is noted. There is severe bilateral foraminal stenosis, left more so than right. The patient underwent bilateral facet injections on 10/26/10 followed by radiofrequency thermocoagulation facets on the left side at L4-5 and L5-S1 on 12/07/10 and on the right side at L4-5 and L5-S1 on 02/08/11. The patient underwent transforaminal lumbar epidural steroid injection at L4-5 and L5-S1 on the left side on 03/22/12 and reported 80% pain relief on 04/09/12. The patient underwent left sided L4-5 and L5-S1 transforaminal epidural steroid injection on 04/26/12.

The patient underwent RFTC facets left L2-3, L3-4, L4-5 and L5-S1 on 07/26/12. The patient reported 100% pain relief for greater than 6 months. Follow up note dated 08/05/13 indicates that medications include Norco, Zanaflex, Skelaxin and Duexis. On physical examination lumbar range of motion is decreased throughout. Straight leg raising is positive bilaterally, no measurement provided. Deep tendon reflexes are intact. Sensation is intact throughout. Motor bulk and tone are normal.

Initial request for lumbar transforaminal epidural steroid injection L4-S1 was non-certified on 08/08/13 noting that the medical documentation provided for review reports that the claimant has been utilizing medications and was recommended to continue physical therapy, but there are no physical therapy progress notes provided for review to document that the claimant has been unresponsive to that conservative measure. In addition, there is no documentation of any ongoing home based exercise program or chiropractic care. The physical examination demonstrated positive straight leg raising bilaterally, but there is no documentation of sensory loss in the lower extremities in a dermatomal pattern or a motor function loss in a myotomal pattern in the lower extremity that would correlate to the requested procedure. The MRI that was provided for review is over 3 years old and demonstrated foraminal stenosis due to ligamentum flavum hypertrophy, degenerative disc disease and facet disease. There is no documentation of any nerve root impingement. There is no documentation of failure of any conservative modalities other than the medications being utilized. The denial was upheld on appeal dated 08/20/13 noting that there is no reflex, sensory or motor evidence. MRI is over 3 years old. There is no recent documentation of physical therapy response nor of adequate home exercise program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has undergone prior transforaminal epidural steroid injections; however, the submitted records fail to document at least 50% pain relief for at least 6 weeks as required by the Official Disability Guidelines prior to performing repeat lumbar epidural steroid injection. The patient's physical examination fails to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines with intact motor, deep tendon reflexes and sensation in the lower extremities. There are no current imaging studies/electrodiagnostic results submitted for review as the most recent submitted lumbar MRI is over 3 years old. As such, it is the opinion of the reviewer that the request for outpatient lumbar transforaminal epidural steroid injection L4-S1 is not recommended 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)