

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Mar/19/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Caudal ESI 62311 w/fluoro

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D. Board Certified Anesthesiology 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 Caudal ESI 62311 w/fluoro is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 01/25/13, 02/21/13

Utilization review referral form dated 02/25/13

Office visit note dated 01/14/13, 01/23/13, 07/30/12, 07/09/07

MRI lumbar spine dated 02/25/11

Radiographic report dated 12/10/12

Log note dated 01/22/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xxxxxx. On this date the patient was lifting a radiator and noted severe pain in the low back. Office visit note dated 07/09/07 indicates that the patient is status post right L4 and L5 transforaminal neuroplasty and reports he had about 60-70% pain relief for about 3 days. The patient is noted to have a history of lumbar fusion on 10/03/06. MRI of the lumbar spine dated 02/25/11 revealed a small disc bulge at L1-2. At L2-3 there is no evidence of significant disc disease, central canal or neural foraminal stenosis. At L3-4 there is mild degenerative facet hypertrophy, no evidence of significant degenerative disc change, minimal bilateral neural foraminal stenosis. At L4-5 there is minimal degenerative circumferential disc bulge without significant central canal stenosis. There is no evidence of significant neural foraminal stenosis. At L5-S1 there are postoperative changes in the anterior spinal canal with some linear areas of fibrosis. There is a small posterior central focal disc protrusion with a small amount of epidural fibrosis involving the anterior right thecal sac. This may involve the exiting right S1 nerve root as it exits the thecal sac. Note dated 07/30/12 indicates that the patient underwent right L5-S1 transforaminal epidural steroid injection and reports 70-80% improvement in pain. Note dated 01/14/13 indicates that the patient presents for intrathecal pump reprogramming. The patient would like to increase the IT pump rate today before trying the caudal injection. The patient's rate was increased by 3%. Follow up note

dated 01/23/13 indicates that the patient's pain is rated as 10/10. Current medications are lisinopril, Plavix, Gabapentin and Lortab. On physical examination there is pain on palpation of the coccyx. Range of motion is limited with lumbar extension and flexion. There is a sensory deficit noted in the right L3, L4 and L5 distribution. Straight leg raising is positive bilaterally for back pain only. Bilateral slump test is positive for back pain.

Initial request for caudal epidural steroid injection with fluoro was non-certified on 01/25/13 noting that the most recent note dated 01/14/13 indicates that the patient would like to increase the IT pump prior to trying caudal epidural steroid injection. The patient's rate was increased by 3% on this date. There are no follow up notes submitted for review documenting the patient's response to this increase. There is no current, detailed physical examination submitted for review. The patient underwent previous epidural steroid injection in November 2012; however, the submitted records fail to document at least 50% pain relief for 6-8 weeks as required by current evidence based guidelines prior to the performance of a repeat epidural steroid injection. The denial was upheld on appeal dated 02/21/13 noting that the patient has had transforaminal epidural steroid injections at the right L5 and S1 on 07/16/12 and 11/26/12. There was no documentation seen that these previous injections resulted in at least 50-70% pain relief for at least six to eight weeks, to substantiate the current request for epidural steroid injection. In addition, the intention to utilize the requested injection in conjunction with active rehabilitation efforts was not expressed in the records.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries on 10/19/05 and most recently has been treated with lumbar epidural steroid injections on 07/16/12 and 11/26/12. The patient's objective, functional response to prior epidural steroid injections is not provided in the submitted records. As noted by the previous reviewer, there is no indication that the requested injection is to be utilized in conjunction with active rehabilitation efforts. As such, it is the opinion of the reviewer that the request for Caudal ESI 62311 w/fluoro 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)