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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

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

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 1 bilateral L5 transforaminal epidural steroid injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

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 1 bilateral L5 transforaminal epidural steroid injection is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 07/15/13, 07/29/13

Designated doctor evaluation dated 03/19/13

History and physical exam dated 08/21/13, 06/26/13, 06/19/13, 06/12/13, 06/05/13, 05/29/13, 07/09/13, 03/07/13, 01/24/13, 07/03/13, 05/20/13

EMG/NCV dated 07/17/13

MRI lumbar spine dated 12/14/12

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. MRI of the lumbar spine dated 12/14/12 revealed at L4-5 bilateral facet arthropathy and ligamentum flavum hypertrophy. There is an annular disc bulge. Superimposed upon this there is a posterior disc protrusion which nearly effaces the thecal sac and contributes to severe central spinal canal and bilateral subarticular recess stenosis; the neural foramina remain patent. At L5-S1 there is bilateral facet hypertrophy. There is an annular disc bulge with a broad based posterior disc osteophyte complex. This contributes to mild left subarticular recess stenosis. The central canal remains patent at this level. Mild bilateral neural foraminal narrowing is noted. Designated doctor evaluation dated 03/19/13 indicates that the patient underwent a course of physical medicine with minor improvement. Diagnoses are listed as lumbosacral spondylosis without myelopathy; lumbar disc displacement without myelopathy; lumbar sprain/strain-resolved; lumbosacral radiculitis; myofasciitis. The patient was determined not to have reached maximum medical improvement. The patient subsequently underwent another course of physical therapy. Note dated 07/09/13 indicates that symptoms persist despite modified activity and PT. EMG/NCV dated 07/17/13 revealed evidence of mild L5 radiculopathy on the right and left. Physical

examination on 08/21/13 indicates the patient is able to heel and toe walk. Motor exam is grossly intact with the exception of 5-/5 right plantar flexion. Deep tendon reflexes are normal bilaterally. Sensation is intact in the lower extremities.

Initial request was non-certified on 07/15/13 noting that a comprehensive sensory examination was not provided in the recent medical report. Although the report emphasizes findings of decreased motor function in the lower extremities, specific dermatomal deficits attributable to L5 nerve root impingement is not noted. Definite diagnosis of radiculopathy at this level cannot be ascertained to correlate with the MRI findings.

The denial was upheld on appeal dated 07/29/13 noting that the most recent physical examination is reported to have been performed 03/07/2013 and at that time there was no documentation of neurological deficits on physical examination, either in sensation, strength or deep tendon reflexes, and there are no recent clinical exam findings documenting neurological deficits on physical examination that correlate with the findings on MRI and the findings on the electrodiagnostic studies.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The Official Disability Guidelines require documentation of radiculopathy on physical examination prior to the performance of lumbar epidural steroid injection. The patient's physical examination fails to establish the presence of active lumbar radiculopathy with grossly intact motor exam, normal deep tendon reflexes and intact sensation in the lower extremities. As such, it is the opinion of the reviewer that the request for 1 bilateral L5 transforaminal epidural steroid injection 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)