

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Oct/22/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** right L5 transforaminal epidural steroid injection under fluoroscopy guidance with sedation

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., 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 Right L5 transforaminal epidural steroid injection under fluoroscopy guidance with sedation is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The patient noticed a pain in the lower back that gradually worsened. Note dated 06/19/14 indicates that the patient has completed 5 of 6 approved physical therapy visits and physical therapy is not helping. MRI of the lumbar spine dated 06/27/14 revealed at L4-5 there is a mild broad based disc protrusion at right paracentral area projecting up to 3 mm. There is associated minimal narrowing of the right neural foramen. Left neural foramen shows no notable narrowing. No disc herniation or bony spinal stenosis is noted. At L5-S1 there is a moderate left paracentral disc protrusion projecting up to 4 mm. At right paracentral region and projecting near the right nerve root exit zone is disc protrusion up to 3 mm. No disc herniation or bony spinal stenosis is noted. Office visit note dated 09/18/14 indicates that the patient continues to work and it flares up the pain. Current medication is Elavil. On physical examination lumbosacral spine notes tenderness to palpation of the spinous process. Straight leg raising is positive on the right. Sensation is intact. There is no weakness in the lower extremities. Deep tendon reflexes are normal throughout.

Initial request for right L5 transforaminal epidural steroid injection under fluoroscopy guidance with sedation was non-certified on 09/22/14 noting that the patient was continuing with chiropractic care which is conservative treatment. The denial was upheld on appeal dated 09/30/14 noting that per the Official Disability Guidelines, there is no evidence-based literature to make a firm recommendation on the use of sedation during an epidural steroid injection. The most recent clinical documentation dated 09/18/14 clearly states on a psychological evaluation that the patient had no anxiety, no depression, no sleep disturbances or insomnia upon examination.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries on xx/xx/xx and underwent a short course of physical therapy. The patient's physical examination fails to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines prior to the performance of an epidural steroid injection. Additionally, there is no documentation of extreme anxiety or needle phobia provided to support the request for sedation. As such, it is the opinion of the reviewer that the request for Right L5 transforaminal epidural steroid injection under fluoroscopy guidance with sedation 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)