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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/30/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: O/P TF LESI L4 L5 S1, sedation, fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Anesthesiology 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 this reviewer that the proposed O/P TF LESI L4 L5 S1, sedation, fluoroscopy would not be medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx. The patient was followed for ongoing post-laminectomy syndrome following a lumbar laminectomy discectomy at L5-S1. The patient had a spinal cord stimulator placed with leads at T9-10. Medication history included analgesics Lyrica, Neurontin, Cymbalta, Zanaflex, and Lidoderm patches. The patient was scheduled for previous epidural steroid injections in July of 2013. This was not performed as the patient was utilizing Plavix. Epidural steroid injection was performed on 08/30/13 with sedation to the left at L4-5 and L5-S1. Follow up on 09/06/13 noted the VAS scores were higher at 7/10 versus 5/10 in 08/13. The patient felt he obtained excellent relief of left lower extremity symptoms for approximately three days following the 08/30/13 epidural steroid injection. The patient underwent posterior lumbar interbody fusion from L3 through S1 at L3-4 followed by posterolateral fusion from L3 through S1 on 03/12/13. The patient was increasing narcotics use through 10/13. The patient was recommended for bilateral L3-4 and L4-5 medial branch nerve blocks on 01/24/14. Follow up on 02/26/14 noted severe low back pain radiating into the left lower extremity despite substantial amount of narcotics. In this note indicated that the patient had months of relief with the previous epidural steroid injection on 08/30/13. The patient reported some progress with a pain psychologist. There were considerations for further epidural steroid injections. Physical examination noted pain over the lumbar facets from L3 through L5 with associated tenderness to palpation. There was mild weakness at the hips. No clear sensory loss was noted. There was hyperesthesia and hyperpathia in a left L5 distribution. Straight leg raise was positive to the left at 60 degrees. Hydromorphone was refilled at this visit and the patient was scheduled for repeat epidural steroid injections to the left at L4-5 and L5-S1. CT of the lumbar spine from 03/12/14 noted post-operative changes from L3 through

S1. Artifacts limited the evaluation of the canal and neural foramina at these levels. There was some slight increase in the amount of canal stenosis at L2-3. Follow up on 04/02/14 noted continuing severe low back and lower extremities pain. Physical examination continued to note tenderness over the lumbar facets from L3 through L5. No clear motor weakness or sensory deficits were noted. The requested L4-5 and L5-S1 epidural steroid injection transforaminally with fluoroscopy and sedation was denied by utilization review on 04/16/14 as there was insufficient objective evidence regarding continuing radiculopathy at the injected at the indicated levels to support repeat epidural steroid injections. There were also limited findings on CT to establish continued nerve root compromise. There was inadequate documentation regarding any recent therapy prior to epidural steroid injections. The request was again denied by utilization review on 06/02/14 due to the limited evidence regarding conservative treatment and lack of evidence regarding the need for sedation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: In review of the clinical documentation submitted for review the patient has been followed for ongoing chronic pain in the low back radiating to the left lower extremity consistent with post-laminectomy syndrome. The patient had additional lumbar fusion procedures in March of 2013 from L3 through S1. The patient has spinal cord stimulator placed. Multiple medications for pain were noted in the clinical record. The clinical documentation submitted for review documented epidural steroid injection on 08/30/13 to the left at L4-5 and L5-S1. The subsequent follow up on 09/06/13 clearly noted that the patient had elevated pain scores versus the previous visit. The patient indicated that he only had three days of relief following epidural steroid injection before his pain returned to the original intensity level. This does not this documentation does not correlate with the later stated efficacy of the epidural steroid injection in records. Given the conflict in the clinical documentation regarding efficacy of prior epidural steroid injections repeat injections as requested would not meet guideline recommendations due to the lack of documented efficacy in the clinical record. This was never addressed in subsequent notes. The clinical documentation record also provides limited objective evidence regarding persistent active radiculopathy. Imaging studies from 2014 were limited due to artifacts and physical examination findings were limited in support for active lumbar radiculopathy. Given the absence of any clear evidence regarding lumbar radiculopathy in the later 2014 clinical notes and documentation regarding lack of efficacy from prior epidural steroid injections, it is the opinion of this reviewer that the proposed O/P TF LESI L4 L5 S1, sedation, fluoroscopy would not be medically necessary per guideline recommendations. As the epidural steroid injection was not indicated the requested sedation and fluoroscopy would also not be medically necessary. As such the prior denials are upheld.

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)