

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Sep/02/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** L5-S1 caudal ESI w/IV sedation

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic Surgery

**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 request for L5-S1 caudal ESI w/IV sedation is not recommended as medically necessary.

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his low back. The patient reported a sharp low back pain with a pulling sensation on the left. The patient rated pain 4/10. Tenderness to palpation was identified along with spasms in the paravertebral musculature. Range of motion was decreased throughout the lumbar spine. Therapy note dated 04/09/14 indicated the patient completing six physical therapy sessions to date. A clinical note dated 04/28/14 indicated the patient rating low back pain 4/10. Tenderness was identified at the left lumbar spine from L3 through S1. Range of motion was decreased. Straight leg raise was positive on the left at 75 degrees and right at 90 degrees. The patient utilized a home exercise program. The MRI of the lumbar spine dated 05/05/14 revealed disc protrusion with mild facet hypertrophy without significant spinal canal or neural foraminal narrowing at L4-5. A broad based disc bulge was identified at L5-S1 without significant spinal canal or neural foraminal narrowing. Clinical note dated 05/08/14 indicated the patient completing 12 physical therapy sessions and home exercise program. Range of motion testing was painful with side bending and flexion. A clinical note dated 05/29/14 indicated the patient showing 4/5 strength at the peroneus at the left EHL/peroneal musculature. The patient was recommended for epidural steroid injection. Utilization review dated 03/16/14 resulted in denial as no information was submitted regarding neurological deficits. A clinical strength at utilization review dated 07/28/14 resulted in denial for epidural steroid injection as insufficient information was submitted regarding any evidence of radiculopathy.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient complained of ongoing low back pain. Epidural steroid injection is indicated in the lumbar spine provided that the patient meets specific criteria, including imaging studies confirming neurocompressive findings. The patient had strength deficits rated 4/5 at the L5 EHL. However, the submitted MRI failed to identify any neurocompressive findings at L5-S1. No neural foraminal or central canal stenosis was identified. Without imaging studies offering confirmatory evidence of any neurocompressive findings, this request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for L5-S1 caudal ESI w/IV 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)