

C-IRO Inc.

An Independent Review Organization

1108 Lavaca, Suite 110-485

Austin, TX 78701

Phone: (512) 772-4390

Fax: (512) 519-7098

Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/28/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L4/5, L5/S1 epidural steroid injection with 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.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a xx year old whose date of injury is xx/xx/xx. On this date the patient slipped on a wet bathroom floor onto his back and neck hitting his head being unconscious for 15 minutes. The patient completed a course of physical therapy. EMG/NCV dated 08/11/14 revealed electrodiagnostic evidence of a chronic, relatively inactive, left L5 radiculopathy. The patient underwent anterior posterior fusion L4 to the sacrum on 04/06/15. Office visit dated 05/21/15 indicates that the patient is status post two level anterior posterior fusion L4-5, L5-S1. His back pain is a lot better. He is having some nerve pain down the left leg. He is taking Lyrica and oxycodone. On physical examination he stands erect. Sit to stand is much better. Incisions are healing nicely both anterior and posterior. There is no swelling in the legs.

Initial request for L4-5, L5-S1 epidural steroid injection with IV sedation was non-certified on 06/02/15 noting that the current medical records did not document specific physical examination findings nor imaging findings supporting the need for the epidural steroid injections post anterior L4-5 and L5-S1 discectomy and fusion. The denial was upheld on appeal dated 06/16/15 noting that there are no reflex, motor or sensory changes. There was no nerve root compression. There are no objective exam or imaging findings consistent with L4-5, L5-S1 stenosis. There are no red flag conditions that warrant epidural steroid injection. CT myelogram was ordered but is not available for review to assess for stenosis.

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 corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active radiculopathy, and there are no postoperative imaging studies/electrodiagnostic results submitted for review. The patient underwent anterior posterior fusion L4 to the sacrum on 04/06/15; however, there is no comprehensive assessment of postoperative treatment completed to date or the patient's response thereto submitted for review. There is no documentation of extreme anxiety or needle phobia to support IV sedation. As such, it is the opinion of the reviewer that the request for L4/5, L5/S1 epidural steroid injection with sedation is not recommended as medically necessary and 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 KNOWLEDGBASE

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)