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An Independent Review Organization

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DATE NOTICE SENT TO ALL PARTIES: Jun/12/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right L5 transforaminal injection

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

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 injection is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as unloading trucks. Follow up note dated 05/27/10 indicates that the patient had a previous laminectomy decompression surgery 40 years ago. Electrodiagnostic study dated 06/10/10 revealed evidence of a mild active right S1 radiculopathy. Follow up note dated 12/16/10 indicates that he is doing well. He has had 3 selective nerve root injections. The patient underwent right L3-4 transforaminal epidural steroid injection on 07/21/14. Office visit note dated 03/31/15 indicates that the patient was last seen about 5 years ago for right sided leg pain due to an L5-S1 disc herniation. The patient underwent 3 selective nerve root injections which helped with the symptoms. He has had no recent treatments of physical therapy or chiropractic care or injections. CT scan of the lumbar spine dated 04/03/15 revealed at L4-5 there is degenerative grade I spondylolisthesis of L4 on L5. A 2-3 mm annular bulge is seen. There is narrowing of the central canal to approximately 6-7 mm. Mild to moderate bilateral neural foraminal narrowing is seen. At L5-S1 disc space height loss is identified. There are 6 mm posterior osteophytic spurs visualized. These lateralize slightly to the right of midline. Degenerative facet joint changes are noted bilaterally. There is moderate right and mild left neural foraminal narrowing. Office visit note dated 05/27/15 indicates that the patient presents with recurrent right low back pain with weakness in the right leg. Current medications are listed as Lyrica, Norco, Tramadol, Advil and Viagra. On physical examination gait is antalgic on the right. There is positive dural tension sign on the right. There is weakness of the right foot and paresthesias in the right L5 distribution. It is reported that a caudal epidural steroid injection was recommended.

Initial request for right L5 transforaminal injection was non-certified on 04/10/15 noting that the patient had a series of these ending in 7/10. The next note of 8/10 stated they, "helped a little", and the next note of 9/10 never quantified any result or duration of effect. Despite the current findings on MRI and exam, the lack of verifiable improvement from the prior series of these injections does not support repeating them at this time. The denial was upheld on appeal dated 04/22/15 noting that the clinical documentation submitted for review does provide

evidence of neurological deficits related to L5; however, it was noted the patient had previous injections and there was no documentation of pain relief of at least 50-70% for at least 6 to 8 weeks, a decreased need for pain medications, and increased function with the previous injections.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in xxxx and underwent a series of selective nerve root blocks in 2010. The patient failed to report at least 50% pain relief for at least 6 weeks as required by the Official Disability Guidelines. It should also be noted that the office visit note dated 03/31/15 indicates that the patient was previously seen approximately 5 years prior, and the patient had not undergone any recent chiropractic care, physical therapy or injection therapy. The Official Disability Guidelines note that patients must initially be unresponsive to conservative treatment including exercises, physical methods, NSAIDs, muscle relaxants and neuropathic drugs. The Official Disability Guidelines also state that chronic duration of symptoms (> 6 months) has been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. As such, it is the opinion of the reviewer that the request for right L5 transforaminal injection 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)