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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/10/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: caudal ESI

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:

[X] 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 <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for a caudal ESI is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The submitted records indicate this patient is a male. On 11/11/13, he was taken to surgery and it was noted he had a prior L4-5 laminectomy with facet dysfunction at L4-5 and L5-S1 with multi-level lumbar spondylosis and received a right L4-5 facet injection and right L5-S1 facet injection. On 12/15/14, imaging studies revealed a congenital narrowing of the spinal canal from L2 to S1 and there was a broad based posterior disc protrusion at L4-5, slightly exceeding the posterior bony spurs lateralizing to the left of midline, deforming the left anterior aspect of the thecal sac. Degenerative facet joint changes were noted. There was moderate bilateral neuroforaminal narrowing seen. Small laminectomies had been performed at that level. There was some granulation tissue noted along the posterior and lateral margins of the spinal canal. A diffused annular bulge was seen at L3-4 with degenerative facet joint changes. On 01/06/15, the patient returned to clinic with reports of back pain and leg pain located to the right side. Imaging studies were reviewed at that time, and it was noted that he had congenital canal stenosis greatest at the L4-5 level. A caudal epidural steroid injection was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 01/02/15, a utilization review report included a peer review in which it was reported the patient had done physical therapy but there was no exam to support doing an ESI despite post-op MRI findings. Until that was documented the recommendation was to non-certify the request. On 01/13/15, a utilization review determination noted that there was no indication that the patient had focal radicular symptoms or focal signs of radiculopathy on exam and it was noted guidelines do not recommend caudal epidural steroid injections for chronic lumbar radiculopathy. It was noted that although the patient may have some residual lumbar stenosis that was questioned by the interpretation of the treating provider following the most recent MRI. Therefore the request was non-certified.

The submitted records for this review include the 01/06/15 progress note at which time it was

noted that the patient reported back pain and leg pain located on the right side but no objective physical examination was provided for that date of service to objectively identify radiculopathy in a particular fashion. Guidelines indicate that radiculopathy must be documented by imaging studies and/or electrodiagnostic studies corroborating the findings on physical examination. As such, it is the opinion of this reviewer that the request for a caudal ESI is not 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 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)