

# MEDICAL REVIEW OF TEXAS

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**DATE OF REVIEW: AUGUST 13, 2007**

**IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Caudal Epidural Steroid Injection Under Fluoroscopic Guidance

## **A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

MD, Board Certified in Neurology

## **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 or not medical necessity exists for each of the health care services in dispute.

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- | Multiple records dating back to 2003 including the MRI reports, x-rays of the left knee, skull x-rays, MRI brain scan
- | Dr. evaluation
- | Dr. evaluations
- | Dr. – multiple physical therapy evaluations and procedure reports
- | DO, nerve conduction study (10/25/05)
- | Multiple records from Texas Department of Insurance

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

A female who when originally injured on xx/xx/xx when she apparently tripped over a box in a freezer falling forward, hitting a wall, landing on the right side of her face. Her first MRI scan of her lumbar spine (1/15/04) reported a bilateral L5-S1 disc herniation slightly displacing downwardly the right and left S1 nerve roots with some mild central spinal canal stenosis. The second and most recent, apparently, MRI scan of the lumbar spine (10/18/05) showed only moderate degenerative changes at L5-S1 involving primarily the disc (with disc desiccation with mild loss in disc height. There was no HNP or central stenosis. There was no neural foraminal narrowing). There were mild degenerative changes at L4-5. There was specific report of no HNP, central stenosis, or significant focal nerve root impingement at any level. The only point of note was perhaps mild narrowing of the right neural foramen at L5-S1, but this would only be significant if there is right L5 radiculopathy. The patient had a caudal epidural by Dr. on 4/27/05, which provided her no benefit for any period of time. She had facet joint blocks on the right at L4, L5, and S1 on 6/15/05 which the patient reported provided her no help for any period of time. There were facet joint blocks again by Dr., on 8/17/05, which provided her a little bit of benefit for about 24 hours. Right selective L5 nerve root injection on 8/17/05 by Dr. gave her 50% relief of symptoms for a 24-hour period of time and that was the most helpful block. The patient underwent trochanteric blocks on 6/8/06 by Dr. On the left side, the patient had a nice response for several months, but her symptoms began to return. On the right side, they did not help. The patient has had extensive physical therapy. There is a report of increasing pain over the right anterolateral thigh by the patient on Dr. chart note on the patient of 6/6/07 with report of positive straight leg raising over the right lateral thigh and calf on that date. There is a report of diffuse tenderness over the lumbar paraspinal segments on the patient's 7/19/07 office visit from Dr. The patient was given an MMI for this injury on 4/13/04 and given between 0-5% impairment rating from Dr.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

THERE IS NO CURRENT DOCUMENTATION OF ANYTHING LIKE RADICULAR PAIN. THERE IS NO DOCUMENTATION BY MRI SCANNING. THERE IS NO CLINICAL DOCUMENTATION OF ANYTHING RESEMBLING RADICULAR PAIN. THE PATIENT IS NOT EXHIBITING ANY OF THE CHARACTERISTICS THAT WOULD JUSTIFY THIS PROCEDURE. THEREFORE, THE PRIOR DENIAL IS UPHOLD.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN 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)