



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 09/03/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Caudal Steroid Injection w/ Monitored Anesthesia Care

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

Board Certified in Physical Medicine & 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 or not medical necessity exists for each of the health care services in dispute.

Caudal Steroid Injection w/ Monitored Anesthesia Care

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- , , M.D., 03/27/09, 04/27/09, 05/29/09, 06/26/09, 07/27/09
- Denial Letter, , 06/05/09, 07/10/09
- Request for IRO Assignment, Dr. , 08/03/09
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient had lower back and bilateral leg pain. She was noted to have post lumbar laminectomy syndrome and chronic pain syndrome since a lumbar fusion in 1993. She was determined to have radiculopathy based on a left straight leg raise, decreased sensation at left L5 and S1 and right S1 and decreased motor strength at left L4, L5 and S1. She has undergone conservative therapy, such as physical therapy. Her medications included Amitiza, Evista, Paroxetine HCl, Aspirin, Ropinirole HCl, Duragesic-75 100 mcg, Lyrica and Lortab.

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

The records available for review document that the patient is with a medical condition of a failed back syndrome. A medical document dated 08/20/09 indicated the patient was on narcotic medication for management of pain symptoms. A medical document dated 08/20/09 indicated that the patient “was doing well on current medications.” The records available for review document that when the patient was evaluated by a physician on 08/20/09, the patient was with symptoms of low back pain referable to the lower extremities. Based upon the records available for review, medical necessity for treatment in the form of a caudal epidural steroid injection with monitored anesthesia would not appear to be of medical necessity.

Per criteria set forth by Official Disability Guidelines, to consider treatment in the form of a lumbar epidural steroid injection, there should be documentation of findings on physical examination consistent with a lumbar radiculopathy, corroborated by diagnostic testing to support the medical condition of a lumbar radiculopathy. In this particular case, the records available for review do not provide any documentation to indicate that recent diagnostic testing has been accomplished to support the presence of a medical diagnosis of a lumbar radiculopathy.

It would appear that the patient is with a medical condition of a lumbar failed back syndrome, and also it would appear that the patient is with a medical history of osteoarthritis evidenced by the fact that there is documentation to indicate that the patient has had a total hip replacement in an affected lower extremity in the past. However, as it relates specifically to medical treatment in the form of a lumbar epidural steroid injection, the documentation presently available for review would not support this requested procedure as one of medical necessity, as there is a lack of objective diagnostic testing to corroborate documented signs and symptoms.

**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)