



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:
877-738-4395

**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 09/02/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Caudal epidural steroid injection (ESI)

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

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

Caudal ESI - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the lumbar spine interpreted by, M.D. dated 03/10/08
Evaluations with, D.O. dated 03/18/10, 04/29/10, 05/27/10, 07/06/10, 08/10/10
X-rays of the lumbar spine interpreted by M.D. dated 03/19/10
An evaluation with Dr. (no credentials were listed) dated 03/26/10
A letter of non-certification, according to the Official Disability Guidelines (ODG),
from D.O. dated 07/19/10
A letter of non-certification, according to the ODG, from, M.D. dated 08/06/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

An MRI of the lumbar spine on 03/10/08 showed multilevel spondylotic disease with bulging. At L5-S1, there was also a disc herniation displacing and impinging the proximal left S1 nerve root within the subarticular recess. ON 03/18/10, Dr.

recommended a lumbar epidural steroid injection (ESI), further physical therapy, and lumbar x-rays. Lumbar x-rays interpreted by Dr. on 03/19/10 showed multilevel spondylosis at L1-L2 and mild scoliosis. Chiropractic therapy was performed with Dr. on 03/26/10. On 04/29/10 and 07/06/10, Dr. recommended another ESI. On 07/19/10, Dr. wrote a letter of non-certification for a caudal ESI. On 08/06/10, Dr. also wrote a letter of non-certification for a caudal ESI. On 08/10/10, Dr. requested an IRO.

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

Dr. does not clearly document radiculopathy on examinations. The patient has intermittent leg pain, but it appears to radiate by large into the posterior thigh. The patient does not have any numbness and does not have any motor weakness. Further, there is no description of the patient's pain medication or anti-inflammatory medication. Additionally, the patient is not having significant pain. At the current time, it is neither reasonable nor necessary as the patient does not meet the criteria set forth in the Official Disability Guidelines (ODG) with clear evidence of radiculopathy. Therefore, the requested causal ESI is neither reasonable nor necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE
- 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)