

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jul/15/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** lumbar caudal epidural steroid 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 and Pain Medicine

**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 lumbar caudal epidural steroid injection is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization review determination dated 05/01/13, 05/29/13, 01/09/13, 02/13/13, 03/18/13  
Lumbar MRI dated 05/10/12  
MRI right thigh dated 02/16/12  
Clinic note dated 05/14/13  
Handwritten note dated 04/16/13, 03/12/13, 01/22/13, 02/12/13, 08/16/12, 10/04/12, 09/04/12, 04/16/12, 02/21/12, 05/22/12, 07/12/12, 06/13/13  
Designated doctor exam dated 09/12/12  
Office visit note dated 12/04/12  
Screening report dated 04/16/13  
Progress summary dated 04/11/12  
Prospective IRO review response dated 06/24/13  
Appeal/reconsideration acknowledgement letter dated 05/21/13  
Follow up note dated 05/14/13, 04/16/13, 03/12/13, 02/12/13, 07/03/12  
Procedure note dated 06/22/12, 02/28/13  
Post designated doctor RME dated 03/07/13  
Peer review dated 04/10/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped on a slope and fell forward trying to avoid falling. She did not hit the ground. MRI of the lumbar spine dated 05/10/12 revealed a moderate sized disc protrusion on the right at L5-S1. Small disc protrusions are noted at the L2-3 and L4-5 levels. The spinal canal is of normal size and no evidence of an intradural lesion can be seen. The patient underwent a course of physical therapy. The patient underwent

transforaminal lumbar epidural steroid injection on 06/22/12. Designated doctor evaluation dated 09/12/12 indicates that MMI is 04/11/12 for recovery from lumbar sprain and strain and completion of physical therapy. The patient was given 0% whole person impairment. The patient subsequently underwent caudal epidural steroid injection on 02/28/13. Another caudal epidural steroid injection was approved on 03/20/13. Post designated doctor RME dated 03/07/13 indicates that there is no evidence of radiculopathy. None of the physicians provided any objective substantiation of such diagnosis or any testing to prove it. agrees with the MMI date of 04/11/12 and 0% impairment rating. Peer review dated 04/10/13 indicates that the current diagnoses related to the injury would include a soft tissue myofascial strain of the paravertebral musculature of the lumbar region of the spine and a myofascial strain of the right hamstring.

Follow up note dated 05/14/13 indicates that the patient reports 70% improvement. On physical examination she has full extension. Muscle stretch reflexes are 2+ and symmetrical at the knees and ankles. Right plantar flexion strength is 5-/5. She continues to exhibit a positive straight leg raising bilaterally.

Initial request was non-certified on 05/01/13 noting that the last epidural steroid injection was approved on 03/20/13 and there has not been a sufficient time period passed to judge efficacy. At this point, per the Official Disability Guidelines, a repeat would require 50-70% pain relief for six to eight weeks, documented objectively. It has only been four weeks since last injection. The ODG specifically does not recommend a series of three injections. The denial was upheld on appeal dated 05/29/13 noting that the patient has not had to use pain medication on a daily basis as she did prior to the injection, but there was no documentation of an acute exacerbation of pain or a new onset of radicular symptoms.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries on xx/xx/xx and has undergone treatment to include physical therapy and lumbar epidural steroid injections. Designated doctor evaluation dated 09/12/12 indicates that the patient reached MMI as of 04/11/12 for recovery from lumbar sprain and strain and completion of physical therapy. The patient was given 0% whole person impairment. Post designated doctor RME dated 03/07/13 indicates that there is no evidence of radiculopathy. None of the physicians provided any objective substantiation of such diagnosis or any testing to prove it. agrees with the MMI date of 04/11/12 and 0% impairment rating. Peer review dated 04/10/13 indicates that the current diagnoses related to the injury would include a soft tissue myofascial strain of the paravertebral musculature of the lumbar region of the spine and a myofascial strain of the right hamstring. The submitted lumbar MRI fails to document any significant neurocompressive pathology. As such, it is the opinion of the reviewer that the request for lumbar caudal epidural steroid injection is not recommended as medically necessary.

**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

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)