



Notice of Independent Review Decision - WC

DATE OF REVIEW: 11/12/14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1 Caudal Epidural Steroid Injection as outpatient

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

Board Certified in PM&R 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 or not medical necessity exists for each of the health care services in dispute:

- 1 Caudal Epidural Steroid Injection as outpatient - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work injury on xx/xx/xx. History is positive for lumbar spine fusions, and he has been diagnosed with post-laminectomy syndrome and thoracolumbar radiculopathy. Radicular pain is noted as not responding to medication therapy. There are no physical therapy records. Recent diagnostic imaging includes a lumbar CT dated 07/21/14. Records indicate the treating physician performed a left sacroiliac joint injection on 10/06/14.

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

It is my medical opinion that the caudal epidural steroid injection of the lumbar spine as proposed is not medically reasonable or necessary. The Official Disability Guidelines requires lack of responsive to conservative treatment and clear cut physical evidence of active radiculopathy plus corroborating evidence on by imaging studies and/or electrodiagnostic testing. The most recent imaging for this patient offers no significant evidence of nerve root compression to corroborate the findings on the physical examination. As such, medically reasonable necessity has not been established.

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

- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**