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DATE NOTICE SENT TO ALL PARTIES: Jun/10/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar caudal injection L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Physical Medicine and 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 medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for lumbar caudal injection L5-S1 is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is XX/XX/XX. The patient sustained a back injury. History and physical dated XX/XX/XX indicates that she states the pain is in her lower back, buttock and left sacroiliac joint. The patient underwent left sacroiliac myofascial trigger point injection on this date. Physical examination on XX/XX/XX indicates that range of motion is restricted with lumbar flexion, extension and left lateral bending. Gait is normal. MRI of the lumbar spine dated XX/XX/XX revealed mild disc height loss at L5-S1 and moderate disc desiccation. There is a broad based central posterior disc protrusion which measures up to 6 mm AP. Mild bilateral facet hypertrophy is also present with associated moderate bilateral foraminal narrowing, left worse than right. There is contact of the exiting right L5 nerve root. Office visit note dated XX/XX/XX indicates that she has seen a chiropractor twice and states she is better. On physical examination lumbar range of motion is painful and restricted. Straight leg raising is positive on the right at 90 degrees and on the left at 75 degrees. Femoral stretch is negative bilaterally. Lower extremities strength is symmetrically present in all muscle groups. Left light touch is abnormal at L5 dermatomes. The patient was recommended for physical therapy and lumbar epidural steroid injection. Initial patient visit dated XX/XX/XX indicates that the patient has been recommended for a caudal epidural steroid injection. Chiropractic did not help. Physical therapy has helped some but she says she has to stop some of the exercises because of pain.

Office visit note dated XX/XX/XX indicates that the patient complains of back pain radiating to both legs. She has been doing physical therapy which helps, but almost 2 weeks ago she felt a sudden pain during an exercise and has been in more pain ever since. On physical examination range of motion is restricted. All lower extremity reflexes are equal and symmetric. Heel and toe walking are normal. Office visit note dated XX/XX/XX indicates that she has completed 6 sessions of physical therapy. She was doing quite well with therapy and feels that it is helping. She would like to continue. On physical examination no focal deficits are found in the lower extremities.

The initial request for lumbar caudal injection L5-S1 was non-certified noting that clarification is needed regarding the steroid injection mentioned in the medical report dated XX/XX/XX. There was no documentation of pain relief, decreased need for pain medications and functional response following the said injection. The denial was upheld on appeal dated XX/XX/XX noting that the patient does not have nerve root impingement on the left L5 or S1 nerve root on MRI. The claimant received no relief from the previous SI joint injection. Letter dated XX/XX/XX from XX indicates that a peer review was never performed with the reviewing physician.

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 when her chair broke. The Official Disability Guidelines require that patients are initially unresponsive to conservative treatment prior to the performance of an epidural steroid injection. Per note dated XX/XX/XX, the patient has completed only 6 sessions of physical therapy to date, and the patient reports that physical therapy is helping and she would like to continue. Per this note, the patient was recommended to continue a course of physical therapy. Therefore, the submitted records fail to establish that the patient has been unresponsive to conservative treatment. Additionally, the Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The most recent office visit note dated XX/XX/XX indicates that on physical examination no focal deficits are found in the lower extremities. As such, it is the opinion of the reviewer that the request for lumbar caudal injection L5-S1 is not recommended as medically necessary and the prior denials are upheld.

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)