

# C-IRO Inc.

An Independent Review Organization

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**DATE NOTICE SENT TO ALL PARTIES:** Feb/19/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Caudal Epidural Steroid Injection Lumbar

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** DO, Board Certified 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 medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that the request for Caudal Epidural Steroid Injection Lumbar is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is XX/XX/XX. On this date a heavy piece of machinery slipped from his grip. The patient underwent transforaminal lumbar epidural steroid injection at L5-S1 on XX/XX/XX, XX/XX/XX. The patient underwent caudal epidural steroid injection on XX/XX/XX, XX/XX/XX, XX/XX/XX, XX/XX/XX. Physical examination on XX/XX/XX indicates that straight leg raising is positive on the left and negative on the right. Motor and sensation are intact in the bilateral lower extremities. Physical examination on XX/XX/XX indicates that lumbar range of motion is normal. Lower extremity range of motion is normal. Deep tendon reflexes are 2+ and symmetrical in the lower extremities. Lower extremity sensation is intact. Lower extremity motor function is normal. Letter dated XX/XX/XX indicates that the patient has undergone two lumbar spine surgeries, including posterior decompression and anterior interbody fusion at L5-S1. He continues to have persistent left lower extremity pain, numbness and tingling and weakness. The patient works part-time. He undergoes occasional epidural steroid injections that he receives every 4 to 6 months.

These injections have been helpful for him and allowed him to continue to work. It has been nearly XX months since his most recent injection. The most recent injection in XX/XXXX produced significant and near-complete relief for XX months. He was still obtaining significant relief of greater than 50% some XX weeks after the procedure.

Initial request for caudal epidural steroid injection lumbar was non-certified on XX/XX/XX noting that there was a lack of documentation of the patient's functional response to the prior injection and the percentage of pain relief was not documented. Moreover, the latest documented examination findings were not suggestive of radiculopathy to support the need for an epidural steroid injection. The denial was upheld on appeal dated XX/XX/XX noting that more recent physical examination findings of clinical radiculopathy were not noted. The guidelines would not support repeat epidural steroid injections unless there is functional response and current physical examination findings of radiculopathy.

**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 he has undergone treatment including multiple injections and surgical intervention x 2. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active radiculopathy with normal sensation, motor and deep tendon reflexes. There are no recent imaging studies/electrodiagnostic results submitted for review. As such, it is the opinion of the reviewer that the request for Caudal Epidural Steroid Injection Lumbar 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)