

# I-Resolutions Inc.

An Independent Review Organization  
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**DATE NOTICE SENT TO ALL PARTIES:** May/13/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Caudal injection lumbar

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** DO, 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 caudal injection lumbar is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is XX/XX/XX. On this date she slipped and fell on ice. Note dated XX/XX/XX indicates that the patient underwent L5-S1 fusion one year ago. The patient underwent bilateral L5 and S1 pedicle screw hardware block on XX/XX/XX followed by L5-S1 exploration of fusion, removal of instrumentation and fusion augmentation on XX/XX/XX. Note dated XX/XX/XX indicates that she is completing physical therapy and is interested in a work conditioning program. Note dated XX/XX/XX indicates that she is enrolled in a return to work program. The patient underwent ventral incisional hernia repair on XX/XX/XX. Note dated XX/XX/XX indicates that the patient has returned to work as a XX. The most recent office visit note dated XX/XX/XX indicates that low back pain is rated as 6/10 and leg pain is 5/10 on the right side L5 pattern. Current medications are listed as Phentermine, Lyrica, Zanaflex, Norco, Inderal, Exforge, Prilosec, Ambien and Xanax. On physical examination there is tenderness right greater than left lumbar paraspinals. She has chronic right L5 deficit to light touch compared to the left side. Straight leg raising worsens the burning down the right leg L5 compared to the left. It is reported that she is currently employed and functioning well. The patient was recommended to undergo a caudal epidural steroid injection.

Initial request for caudal injection lumbar was non-certified on XX/XX/XX noting that no updated studies are submitted for review. There is no documented response to prior caudal epidural steroid injection. There are limited neuro findings on physical examination. The denial was upheld on appeal dated XX/XX/XX noting that the review of available medical records does not document the clinical response of the previous caudal epidural steroid injections for this claimant. There is no documented objective pain relief, a decreased need for pain medications and/or improved functional response as a result of the previous caudal epidural steroid injections for this claimant which might warrant repeat injections.

**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 as a result of a slip and fall. The patient has been recommended to undergo a

caudal epidural steroid injection. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. There are no imaging studies/electrodiagnostic results submitted for review. There is no documentation of any recent active treatment. There is an indication that the patient has undergone prior caudal epidural steroid injections; however, there is no information provided regarding these procedures including dates of service and patient response. As such, it is the opinion of the reviewer that the request for caudal 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)