

# P-IRO Inc.

An Independent Review Organization  
835 E. Lamar Blvd., #394  
Arlington, TX 76011  
Phone: 817-274-0868  
Fax: 866-328-3894

## IRO REVIEWER REPORT TEMPLATE -WC

---

### **DATE OF REVIEW:**

10/22/07

### **IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Left L4/L5 transforaminal epidural steroid injection under fluoroscopy and MAC anesthesia

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

M.D., neurologist and fellowship trained pain specialist, board certified in Neurology and Pain Management

### **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.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

No ODG Guidelines

1. Denial determination dated 08/23/07 as well as 09/20/07
2. Medical dispute resolution letter by Dr. dated 09/22/07
3. Report of lumbar MRI scan dated 07/27/07
4. Letter for reconsideration by Dr. dated 09/05/07 including Exhibit 1, Exhibit 2, Exhibit 3, Exhibit 4
5. Patient history and physical examination form dated 08/08/07 by Dr.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant sustained a work-related injury. She has had low back pain with radiation into the left leg with examination findings reportedly showing sensory as

well as motor deficits in the L4/L5 dermatomes and myotomes as well as a positive straight leg raise test on the left. MRI scan does report a moderately severe central stenosis at the L4/L5 level along with posterior annular tears seen at the L3/L4 and L4/L5 levels. A mild anterior listhesis of L4 on L5 is also noted. Based on the claimant's radicular symptomatology as well as MRI scan findings, the transforaminal lumbar epidural steroid injection procedure has been requested. Apparently facet joint injections in the lumbar spine have already been tried without significant sustained benefit. EMG study has not been completed, the lack of which apparently has resulted in denial of the requested service.

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

It is quite apparent that this claimant is demonstrating both symptoms and signs compatible with a left-sided lumbar radiculopathy and does have MRI evidence to potentially correlate with the presentation. Certainly, radicular dysfunction and/or irritation of the proposed nerve roots can be taking place (either from compression noted from the disc herniation or perhaps chemical irritation from the annular tear). These etiologies may be present without necessarily documenting radicular dysfunction on EMG study. Therefore, the reviewer believes that the presentation certainly is compatible with radiculitis and that a lumbar epidural steroid injection, as recommended, would be appropriate and medically necessary. Specifically, the reviewer disagrees with the previous reviewers in their assertion that electrodiagnostic studies are needed to objectify the presence of radiculopathy. The imaging studies as well as the claimant's presentation, both by symptoms and findings on examination, clearly point toward a lumbar radiculopathy in the left lower extremity.

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

- ACOEM- AMERICAN 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)