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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L4-5 Transfor. ESI with Fluoro, 64483, 77003, 99144

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 12/29/08, 2/5/09

ODG Guidelines and Treatment Guidelines

, MD, 1/16/09, 5/29/08, 11/20/08, 8/19/08, 7/24/08, 1/30/08

MRI, Lumbar Spine, 8/31/07

, MD, 9/23/08, 6/17/08

PATIENT CLINICAL HISTORY SUMMARY

This patient has a history of low back pain. The records indicate the patient received a left L4-5 epidural steroid injection. However, the exact date of this ESI was not included in the medical records provided for this review. The patient was reported on 7/24/08 to have received about 90% pain relief at the initial follow-up visit after the ESI. After that time, there is no mention as to how much pain relief the patient had or any specifics regarding any improvement in function. There is no mention specifically as to how long this pain relief lasted. Many of the notes state only that the patient "feels better." Again, there are few specifics mentioned as to how much pain relief the patient was receiving and if there was any improvement in function or decrease in medications. A note from Dr. on 01/16/09 states that the injection provided the claimant with at least a year's worth of pain relief, but there was no mention in that note as to how much pain relief she received for that year.

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

Per the Official Disability Guidelines, when considering an epidural injection in the therapeutic phase, there needs to be documentation of at least 50-70% pain relief that lasts for at least 6-

8 weeks. In addition, there needs to be other documentation of a decreased need for pain medications and any increase in functional response. A note from Dr. on 01/16/09 states that the injection provided the claimant with at least a year's worth of pain relief, but there was no mention in that note as to how much pain relief she received for that year. The request does not meet the criteria in the ODG. The reviewer finds that medical necessity does not exist for Left L4-5 Transfor. ESI with Fluoro, 64483, 77003, 99144.

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)