

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Nov/02/2009

**IRO CASE #:**

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

Epidural Steroid Injection with Epidurogram, 62311, 72275)

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

M.D., Board Certified Orthopaedic Surgeon  
Board Certified Spine Surgeon  
Diplomat of the American Academy of 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines and Treatment Guidelines  
Adverse Determination Letters, 9/8/09, 9/14/09  
MD, 9/23/09, 9/10/09, 8/31/09, 9/8/09  
Chart Note, 8/31/09  
Lumbar Spine X-Rays, 8/24/09  
MRI Lumbar Spine, 8/11/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male who injured his back while at work on xx/xx/xx. The patient has had some conservative care. The patient has documented radiculopathy on physical examination with a positive straight leg raising and radicular pain in the leg and numbness. The clinical findings are compatible with the MRI scan findings, showing an 8-mm to 10-mm disc protrusion at L4/L5 and a 5-mm to 6-mm protrusion at L5/S1.

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

Based upon the Official Disability Guidelines and Treatment Guidelines, the use of epidural steroid injection are appropriate in cases of documented radiculopathy. This gentleman's MRI scan findings and his physical findings are conclusive of a radicular complaint. Hence, this request does conform to the Official Disability Guidelines and Treatment Guidelines. It is

for this reason that this previous adverse determination has been overturned. The reviewer finds that medical necessity exists for Epidural Steroid Injection with Epidurogram, 62311, 72275).

**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)