

SENT VIA EMAIL OR FAX ON
May/15/2010

P-IRO Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
May/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient lumbar epidural steroid injection (ESI) at L4/5

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

OD Guidelines
Denial Letters 4/8/10 and 4/20/10
3/31/10 and 4/8/10
MRI of the lumbar spine report 3/26/10

PATIENT CLINICAL HISTORY SUMMARY

This is a female with a date of injury xx/xx/xxxx when she was thrown off a lawnmower. She complains of back bilateral leg pain. She has undergone chiropractic therapy and medications. Her examination reveals a decreased right patellar reflex. An MRI of the lumbar spine 03/26/2010 reveals a prominent disc bulge, moderate facet joint degenerative disease with ligamentum flavum hypertrophy, causing mild stenosis, and mild bilateral neuroforaminal narrowing, slightly greater on the left. She has undergone chiropractic therapy and medications. The provider is requesting an outpatient ESI at L4-L5.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The ESI is medically necessary. Although mild, there is bilateral foraminal stenosis at L4-L5. The claimant has a decreased right patellar reflex, which can be caused by an L4-L5 process. She therefore, has objective evidence of a radiculopathy that correlates with her neuroimaging. The L4-L5 ESI is appropriate and medically necessary, and meets the ODG criteria for ESI listed below.

References/Guidelines

Occupational and Disability Guidelines, “Low Back” chapter
Criteria for the use of Epidural steroid injections:

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)