



Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 11/17/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection at L5/S1 with fluoroscopy

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in private practice of Pain Management full time since 1993

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Medical necessity has not been demonstrated for the requested procedure.

Primary Diagnosis Code	Service Being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim #	Upheld Overturn
			Prosp						Upheld

INFORMATION PROVIDED FOR REVIEW:

- Certificate of Independence of the Reviewer.
- TDI case assignment.
- Letters of denial 09/16/10 & 10/13/10, including criteria used in the denial, and correspondence dated 11/10/10.
- Maximum medical improvement rating 09/10/10.
- Orthopedic follow up visits 08/23/10, 08/30/10 & 09/23/10.
- Radiology reports 06/18/10 & 08/26/10.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual was injured on xx/xx/xx. She has had an L3/L4 and L4/L5 fusion. An MRI scan performed on 06/25/10 reportedly demonstrated an 8-mm right paracentral protrusion at L5/S1. Physical examination shows 4/5 muscle strength in the bilateral lower extremities.

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

ODG Guidelines require correlation of evidence of radiculopathy from physical examination and on MRI scan. There is an L5/S1 herniation and decreased strength in the lower extremities, but the muscle groups have not been specified. Therefore, the

correlation between physical examination and MRI scan, which establishes radiculopathy, has not been achieved. It is not reasonable to perform lumbar epidural steroid injection per ODG Guidelines.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)