

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Oct/04/2010

**IRO CASE #:**

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

Epidural Steroid Injection, L4-L5, #2 Under Fluoroscopy

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

MD, Board certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics. Medical Director of Rehabilitation.

**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**

Official Disability Guidelines

Inc. 8/24/10, 9/14/10

Solutions 7/15/10

7/23/10, 6/15/10, 6/25/10

Group 5/18/10 to 6/3/10

Imaging 5/7/10

5/13/10 to 9/3/10

**PATIENT CLINICAL HISTORY SUMMARY**

This claimant has a date of birth of XX/XX/XX. He does have a history of laminectomy and fusion 30 years ago. He was working as a and lifting gauges that weighed 45-55 pounds on XX/XX/XX. He reported low back pain with radiation to the leg. He was first managed on Naprosyn and flexeril. This was stopped and he was taking a medrol dose pack, ultracet, tramadol and lyrica. The therapy notes from 6/10/2010 to 7/5/2010 show he was improving. He did have an ESI approved. This was performed and followed up on 7/23/2010 -- the patient stated he had only 40% improvement that lasted 2 weeks. The pain was returning and flexeril was added to his medications. He did RTW on 4/26/2010 with restrictions. The patient does smoke 1.5 packs per day.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS**

#### **AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The ODG guidelines state that ESI is for short-term relief of pain so that functional activities can be increased. ESI do not allow long-term relief of symptoms. ESI should not be provided in a series of 3. The results of the first ESI should be evaluated to determine if further ESI should be approved. The ODG indicates there should be 50% improvement for 6-8 weeks to consider additional injections. This patient was benefitting from more conservative care – the PT notes indicate there was improvement. The ODG criteria for use of ESI has not been satisfied in this patient's case. The reviewer finds that medical necessity does not exist at this time for Epidural Steroid Injection, L4-L5, #2 Under Fluoroscopy.

#### **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)