



7331 Carta Valley Drive | Dallas, Texas 75248 | Phone: 214 732 9359

Notice of Independent Review Decision
Amended and Sent 3/29/2011

DATE OF ORIGINAL REVIEW: 3/26/2011

DATE OF AMENDED REVIEW: 3/29/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Left L4/5 Transforaminal ESI Injection w/sedation 64483 77003-26 99144-PNR

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

D.O. whose specialty is Anesthesiology and 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)



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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Notice of Case Assignment	3/7/20XX
Insurance company.	1/20/20XX
URA findings	3/7/20XX
Clinic	
Physician Orders	6/14/20XX
Progress Notes	7/15/20XX
C/T Spine Lumbar WO contrast	5/28/20XX
Discharge Summary	7/27/20XX
Clinic	
MR T-spine and L-spine	8/9/20XX
Clinic Follow Up	9/27/20XX
Consultation	2/15/20XX
Radiology Report	9/27/20XX
Script for Orders	1/12/20XX
Clinic	
Progress notes	6/8/20XX -11/17/20XX
Clinic	
Radiography Note	10/19/20XX
Operative Report	10/19/20XX
Report of Medical evaluation	11/8/20XX
Physician	
Designated Doctor Examination	11/8/20XX
Office Visits	4/22/20XX-9/21/20XX



PATIENT CLINICAL HISTORY [SUMMARY]

Patient is a XX year old who sustained a work-related injury on XX/XX/XXXX when a someone grabbed him and his back “popped,” resulting in back pain and leg pain. Patient underwent a left transforaminal epidural at L4-5 on 10/19/20XX. According to the records, back pain improved from 6/XX to 4/XX, leg pain improved from 6/XX to 2/XX.

Diagnostic imaging MRI lumbar spine showed facets changes and a broad based protrusion at L4-5 compromising both the L5 and S1 nerve roots. Disc desiccation at L4-5 and L5-S1.

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

Although Patient showed pain relief for one and a half months after the left transforaminal epidural, the medical records did not provide the percentage of pain relief with the left transforaminal epidural. Also, the medical records did not show any objective documentation of decreased need for pain medication and increase in functional capacity. In fact, according to the records, the patient continues to take 4-5 Norco a day and Mobic, dosage not provided on either medication. Based on the clinical information submitted for this review, and using ODG guidelines outlined above, the request for L4-5 left transforaminal epidural steroid injection with sedation is not certifiable.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE 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**



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- 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)**