



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 8/23/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

INJECTION(S), ANESTHETIC AGENT AND/ OR STEROID, TRANSFORAMINAL EPIDURAL WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL, SINGLE LEVEL

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

D.O. Board Certified in 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 |
|------------------------------------------------------------|------------------------------------|
| Texas Department of Insurance Notice of Case Assignment | 8/03/2011 |
| Utilization Management | |
| Utilization Review Determinations | 7/12/2011-7/25/2011 |
| Utilization Management | |
| Case Assignment | 8/03/2011 |
| MRIoA Case Review Decisions | 2/02/2011-7/22/2011 |
| Imaging X-Ray Thoracic Spine | 11/11/2009 |
| M.D., P.A. Request for MRI Clinical Notes | 12/12/2008 12/02/2011-5/16/2011 |
| Radiology Center MRI Report | 11/25/2008 |
| Imaging Radiology Reports | 11/10/2008-6/01/2010 |
| Radiology & Imaging Pre-Authorization Request | 6/29/2011 |
| Texas Workers' Compensation Work Status Report | 12/21/2010-5/16/2011 |
| Workers' Compensation Utilization Review Requests | 3/28/2011-6/28/2011 |
| Injury Prevention Associates Electrodiagnostic Results | 2/17/2008-12/17/2008 |
| M.D. Note | 10/29/2010 |
| Health system Radiology Report | 9/22/2008 |
| M.D. Examination Report | 1/27/2011 |
| L.L.P. Reconsideration Request | 7/20/2011 |

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who had an injury on xx/xx. He suffered major body trauma including back pain and bilateral leg pain. He had two MRIs, one in 2008 and one in 2010. The most recent MRI dated 6/01/2010 revealed no



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canal stenosis, or disc bulges at L5-S1, disc degeneration was noted at L5-S1. EMG performed in February 2008 showed right S1, and bilateral L5 radiculopathy. According to the documents reviewed, the patient had two sets of lumbar epidural steroid injections by Dr., one on 1/27/2011 with documentation stating that patient had 15 % relief. Dr. saw the patient on 1/24/2011 and documented that patient admits to having ESI and facet injections from Dr. with little to no relief. On 3/14/2011 Dr. documented that patient denies any physical therapy but admits to cervical ESI 18 months ago without relief. On physical exam, the patient has severe back pain, positive bilateral leg raise test at 60 degrees laying and 45 degrees sitting, pain over the facet area in the lumbar spine bilaterally, deep tendon reflexes intact and pulses intact.

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

After reviewing the records, the request for L4-5 transforaminal epidural steroid injection **is not certifiable.**

The patient did not have good relief from previous epidural steroid injections, according to the records the patient only had 15% relief. Since the record reflects a poor response to the previous epidural steroid injections and ODG requires at least 50% – 70 % relief for at least 6-8 weeks, the patient does not meet ODG criteria.

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
- 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



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- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES