

C-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: January 31, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Transforaminal Epidural Steroid Injection Bilateral L5-S1 with Fluoroscopy

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

MD, 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Denial Letters, 12/15/10, 1/11/11

Pain and Spine Center 1/7/10 to 12/8/10

Orthopaedic Surgery Group 10/22/09

Medicine and Rehabilitation Associates 7/14/10

M.D. 12/15/10

Official Disability Guidelines and Treatment Guidelines, ESI

PATIENT CLINICAL HISTORY SUMMARY

In the most recent exam note, this patient describes "lower back pain and lower extremity pain." The exact legs affected are not mentioned. In addition the location of the pain in the lower extremities is not described. The physical exam is confusing. It states that the straight leg raise test was "positive at L4 and L5 with diminished sensation and diminished strength, L5-S1." This statement is difficult to interpret since the results of a straight leg raise test should be either positive or negative. This does not pinpoint affected dermatomes, which is suggested. It is not noted whether these results were bilateral or unilateral.

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

The reviewer finds that there is no medical necessity at this time for Lumbar Transforaminal Epidural Steroid Injection Bilateral L5-S1 with Fluoroscopy. To consider epidural steroid injections for treatment the ODG requires that "Radiculopathy must be documented. Objective findings on examination need to be present (and) radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing." As stated above, the

radicular symptoms were not described sufficiently to corroborate with the physical exam or MRI results. The guidelines have not been satisfied at this time and further information would be needed in order to have the patient meet the guidelines for the procedure.

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)