

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/24/2011

**IRO CASE #:**

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

Left L5 and S1 Transforaminal Epidural Steroid Injection with Epidurogram

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

MD, Board Certified Anesthesiologist

Board Certified 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**

Official Disability Guidelines

Services Corporation, 05/10/11, 05/25/11

Office visit note dated 05/04/11, 03/15/11

Letter dated 06/02/11

MRI of the lumbar spine dated 01/31/11

Fax cover sheet dated 04/20/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xxxx. On this date the patient reports that she injured her low back. MRI of the lumbar spine dated 01/31/11 revealed mild disc bulge centered to the left of midline at L5-S1 without canal or foraminal stenosis; otherwise essentially negative. Office visit note dated 03/15/11 indicates that the patient has completed 10 sessions of physical therapy and reports she is feeling much better. Office visit note dated 05/04/11 indicates that the patient complains of left lower lumbar spine pain that does not radiate. On physical examination there is pain to palpation over the left lumbar paraspinal muscles. Range of motion is full. Sensation is intact throughout the bilateral lower extremities. Deep tendon reflexes are 2/4 and symmetrical. Muscle strength is rated as 5/5 throughout. Straight leg raising is positive for radiculopathy on the left and for back pain on the right. The insurance company reviewer denied the request on 05/10/11 noting that MRI failed to reveal any evidence of neurocompression. Physical examination findings revealed no evidence of a radiculopathy with no advancing motor or neurologic deficits. The denial was upheld on appeal dated 05/25/11 noting that there is no radiation of pain. There is no documented radiculopathy by EMG/NCV or nerve root impingement on MRI.

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

This patient complains of left low back pain that does not radiate. The patient's physical examination does not establish the presence of active lumbar radiculopathy, and the

submitted lumbar MRI does not support the diagnosis. Given the lack of documented radiculopathy, the requested Left L5 and S1 Transforaminal Epidural Steroid Injection with Epidurogram is not found to be medically necessary. The Official Disability Guidelines for ESI have not been satisfied and no explanation has been provided for why there should be a divergence from ODG in this patient's case.

**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)