



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

**DATE OF REVIEW: 10/15/2011**

**IRO CASE #:**

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

OUTPATIENT LUMBAR TRANSFORAMINAL EPIDURAL STEROID INJECTION (ESI) TO THE BILATERAL L5 LEVELS.

**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
Notice of Case Assignment	
Notice of Utilization Review Findings	
Requests for Pre-Authorization	
Notice of Independent Review Decision	
Employee's Report of Injury	
Notice of Disputed Issue and Refusal to Pay	
The Notice of Disputed Issue and Refusal to Pay	
Apex 3T MRI MRI Reports Left knee, Left Ankle	
Imaging MRI of Lumbar Spine Report	
Travel Card Active Rehab Treatment	
Chiropractic Physical Therapy Note Reevaluation report	
IOSM Progress Notes Knee Evaluation Report Note Regarding a Phone Conversation	
Impairment Rating	
Dr. MMI report	
M.D. Office Visit Report	
Genesis Designated Doctor Evaluation	

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is a female who was injured xx/xx/xx when she slipped. Most recent MRI of the lumbar spine dated 3/1/11 showed a l4-5 broad based central disc protrusion effacing the ventral thecal sac and in close proximity of bilateral l5 nerve roots. There was mild to moderate central canal stenosis due to disc protrusion and bilateral facet hypertrophy and ligamentum flavum thickening. EMG performed on 3/3/11 showed mild right l-5 radiculopathy. Patient did have a right l4-5 transforaminal epidural steroid injection on 5/18/11. On 5/31/11, patient reported 75% relief of her symptoms. On follow-up dated 6/27/11 patient reported some improvement in the back and leg on the right but now she is complaining of a left side pain. On physical examination, she had a positive leg raise test bilaterally with associated decrease sensation on the left thigh and deep tendon reflexes were equal bilaterally.



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

Although the EMG shows only a right L4-5 radiculopathy, the MRI did show a broad based disc protrusion @ L4-5 measuring 3-4 mm in AP extent, effacing the ventral sac and in close proximity to the L-5 nerve roots. On physical exam the patient exhibited decreased sensation over the left thigh and a positive straight left leg raise test. In my opinion, the patient has sufficient objective findings, and supported by MRI findings, to warrant certification for one left transforaminal epidural steroid injection @ L4-5 under fluoroscopy with epidurogram.

Also, because patient is a diabetic, she most probably has diabetic neuropathy which is contributing to her pain in her lower extremities. However, the above findings i.e., MRI and EMG show positive pathology.

**References:** Official Disabilities Guidelines and Treatment.

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