

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/19/2012

**IRO CASE #:**

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

Left L5 transforaminal ESI

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

M.D., Board Certified Anesthesiology/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

Utilization review determination dated 12/23/11, 11/09/11

Office visit note dated 11/02/11, 09/14/11, 05/23/11, 05/08/11, 09/18/11, 08/26/11, 08/19/11, 07/27/11, 07/22/11, 07/20/11, 07/15/11, 07/14/11, 07/12/11, 06/23/11, 06/21/11, 06/17/11, 06/13/11, 06/08/11, 06/01/11, 05/31/11, 07/19/11, 05/20/11, 05/26/11, 05/31/11, 09/14/11, 07/19/11, 06/02/11

Letter of medical necessity dated 12/28/11

MRI lumbar spine dated 06/06/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. She was lifting a large canister and twisting to set it down on a cart when she experienced severe low back pain. MRI of the lumbar spine dated 06/06/11 revealed evidence of posterior central, left paracentral radial annular tear at L4-5 with associated broad based posterior central, left paracentral disc protrusion without extrusion and impression upon the thecal sac, abutting against the exiting left nerve root of L5. There is secondary minimal degree of central spinal canal stenosis. At L5-S1 there is a posterior central, left paracentral radial annular tear and associated posterior central, left paracentral broad based disc protrusion without extrusion and impression upon the thecal sac but there is no involvement of the respective exiting right or left nerve root of S1. The patient underwent a course of physical therapy and noted an improvement in her functional status. Note dated 09/14/11 indicates that the patient continues to have pain despite lumbar epidural steroid injection. Follow up note dated 11/02/11 notes that the patient presents with low back pain radiating to the left lower extremity. On physical examination strength is rated as left foot flexors 4, left EHL 3, right foot flexors 5 and right EHL 5.

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

There is no current, detailed physical examination submitted for review to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines prior to the performance of a lumbar epidural steroid injection. The most recent progress note submitted for review dated 11/02/11 notes only that strength is rated as left foot flexors 4, left EHL 3, right foot flexors 5 and right EHL 5. The reviewer finds no medical necessity for Left L5 transforaminal ESI.

**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)