

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Mar/05/2012

**IRO CASE #:**

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

outpatient left L5 transforaminal epidural steroid injection

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

M.D., Board Certified Physical Medicine and Rehabilitation

**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 01/25/12, 02/15/12  
Office visit note dated 11/11/11, 12/23/11, 01/20/12, 10/27/11  
Post injection diary dated 12/07/11  
MRI lumbar spine dated 10/25/11  
Procedure note dated 12/07/11, 01/04/12

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was getting out of a full size pick-up truck when he stepped on a rock and twisted. MRI of the lumbar spine dated 10/25/11 revealed L5-S1 disc contour abnormalities, osteophytes and facet hypertrophy cause moderate spinal canal stenosis and severe stenosis of the left lateral recess as well as neural foraminal stenosis. There is mild spinal canal stenosis with accompanying left neural foraminal stenosis at L3-4 and L4-5. Note dated 11/11/11 states that the patient was in severe pain and could not do any therapy. The patient underwent left L5 transforaminal epidural steroid injection on 12/07/11. Post injection diary notes 10% improvement. Follow up note dated 12/23/11 states that the injection helped the left lateral thigh pain and calf pain has resolved. The patient underwent left L4 selective epidural steroid injection on 01/04/12. Follow up note dated 01/20/12 indicates that the patient reported 70% relief of his anterior thigh pain and 40-50% relief of his back pain. On physical examination straight leg raising was positive on the left and negative on the right.

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

This patient underwent previous epidural steroid injections on 12/07/11 and 01/04/12. The submitted records fail to document that the patient received at least 50-70% pain relief for at least 6-8 weeks as required by the Official Disability Guidelines. The post injection pain diary dated 12/07/11 reports 10% improvement. Follow up note two weeks after the second injection notes 70% relief of anterior thigh pain and 40-50% relief of back pain; however,

there is no more recent follow up documenting adequate pain relief for 6-8 weeks. Additionally, there is no indication that the patient has undergone any physical therapy. There is no current, detailed physical examination submitted for review to establish the presence of active lumbar radiculopathy, as the exam performed on 01/20/12 notes only positive straight leg raising on the left. The reviewer finds that medical necessity has not been established for the requested outpatient left L5 transforaminal epidural steroid injection.

**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)