



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 11/04/13

IRO CASE #:

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

Texas-licensed M.D., board certified in Anesthesiology, added qualifications in Pain Medicine

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L3-4 transforaminal epidural w/selective nerve root block.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- X** Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
756.12			Prosp.				Xx/xx/xx		Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. case assignment.
2. Letter of denial 10/04/13, including criteria used in the denial.
3. Treating doctor evaluations and follow up 11/08/11 -09/13/13.
4. Operative report 07/28/11.
5. ODG-TWO treatment guidelines – low back – lumbar & thoracic.

PATIENT CLINICAL HISTORY (SUMMARY):

This female sustained a fall on xx/xx/xx. After failure of conservative care she underwent an L4 through S1 fusion on 12/14/06. On 07/28/11, a right L3/L4 transforaminal epidural steroid injection and selective nerve root injection were performed. The claimant noted no change in symptoms after this procedure. An MRI scan on 07/12/13 was reported to show severe L3/L4 stenosis and bilateral foraminal stenosis. The office note on 08/12/13 described bilateral posterior thigh pain. There was no documentation of a radicular distribution of pain and no objective evidence of radiculopathy. The note of 09/13/13 stated that there were lower extremity radicular symptoms. Physical exam revealed tenderness in the paraspinal muscles, subjective decreased sensation and hyperesthesia, but no documentation of radiculopathy

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

ODG requires objective evidence of radiculopathy, which has not been demonstrated. This claimant had an epidural steroid injection at the same level on the right side on 07/28/11, which was not beneficial. ODG requires at least 50% improvement in symptoms at four to six weeks after the procedure to meet criteria for a repeat injection. These criteria are not met. Official Disability Guidelines are not met for the requested epidural steroid injection.

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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
- AHCPH-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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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)