



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 12/02/2013

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Injection, diagnostic/therapeutic substance; lumbar Epiduragram.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Department of Insurance Notice of Case Assignment	11/12/2013
Adverse Determination Letters	9/26/2013-10/31/2013
Notice of Disputed Issue and refusal to Pay Benefits	6/04/2008-4/19/2010
Office Visit Notes	3/05/2012-9/16/2013
Operative Report	9/13/2012-6/27/2013
MRI Report	5/31/2012
Pre- Certification Letter	10/1/2013

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who had a work related injury on xx/xx/xx. He was diagnosed with lumbar radicular syndrome, lumbar myalgia, idiopathic scoliosis, lumbar spondylosis, lumbar spondylolesthesis, and osteoarthritis of the spine. Patient had an MRI of the lumbar spine on 6/27/2012 with the results showing grade one spondylolesthesis at L4-5, and bilateral pars defect at L4 with severe left and moderate to severe right I4-5 neuroforaminal narrowing, moderate to severe right neuroforaminal narrowing at L5-S1. Patient did have previously diagnostic facet injections with 90% relief at L3-S1 and subsequently a lumbar rhizotomy at the same levels. Patient also underwent physical therapy and is taking oral medication including narcotics. Last physical exam performed on September 16, 2013 noted back pain with bilateral



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radicular component with associated neurologic deficit, paresthesia at L5-S1 bilaterally, and positive straight leg test bilaterally. Previous caudal epidural performed on 6/27/2013 resulted in a reported 70% relief for more than six weeks.

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

Per ODG references, the requested "Injection, diagnostic/therapeutic substance; lumbar Epiduragram" is not medically necessary due to the reported relief of 70% for more than six weeks.

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 KNOWLEDGE BASE
- 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