



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

Notice of Independent Review Decision

**DATE OF REVIEW: 1/31/2013**

**IRO CASE #**

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

Left L4 & L5 Transforaminal ESI.

**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
Texas Department of Insurance Notice of Case Assignment	1/11/2013
Notification of Reconsideration Determination Notification of Adverse Determination	12/27/2012 12/03/2012
NCV/EMG Report	7/12/2010
Office Visit Notes	6/14/2010-11/27/2012
MRI Report	2/10/2012-2/11/2010



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

Family Medicine Office Clinic Note	10/15/2012
---------------------------------------	------------

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is male who was injured at work when he slipped on ice and sustained an injury to his back and left hip on xx/xx/xx. He was treated with conservative therapy, had EMG on 7/12/2010 that was not definitive, but showed acute and chronic L5-S1 radiculopathy vs. a mononeuropathy of the superficial branch of the left peroneal nerve. MRI of the lumbar spine was performed on 2/10/2010 showed diffuse bulging disc and hypertrophy of the ligamentum flava resulting in a triangular configuration of the thecal sac and bilateral recess stenosis at both L3-4 and L4-5 with possible impaction of the L4 and L5 nerve roots respectively. The encroachment on the left lateral recess is slightly more prominent at L4-L5 than on the right, at L3-L4 the lateral recess is symmetrical.

Patient received two left L4 and L5 ESI in 2010 with better pain relief in the second than the first.

On 10/15/2012 physical examination patient had back pain bilaterally with left side worse than right and burning sensation. Patient was referred to pain clinic and was seen on 10/30/2012, physical exam showed back pain radiating to the left buttock and lateral aspect of the left thigh and dorsum of the left foot. Positive straight left leg raise test, positive left slump test, and sensory deficit left L5 distribution.

Patient's last ESI was on 11/12/2012 with 50% improvement in pain. When he presented to physician's office on 10/15/2012 claiming the back pain has returned three month prior to his visit.

Patient is presently on Tramadol, Meloxicam, Aspirin, Pravastatin, and Toprol XL. He was seen for a follow up visit on 11/27/2012 and reported 50% relief from the ESI but continues to complain of left leg and back pain.

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

Per ODG references the requested left L4 & L5 Transforaminal ESI is not medically necessary.

Patient's duration of relief was less than the recommended 6-8 weeks by ODG guidelines, the Physical exam done on 10/27/2012 was very limited and no functional response to the medication was noted.

The request for a repeat left Transforaminal ESI is not certifiable.



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

**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