



Southwestern Forensic
Associates, Inc.

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE: February 26, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right and left transforaminal epidural steroid injection, L4/L5 and L5/S1

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

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since 1993.

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)

The requested right and left transforaminal epidural steroid injection, L4/L5 and L5/S1 are not indicated for this patient.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Denial information
2. TDI Referral information
3. Notes, 4/19/12-11/5/12
4. MRI lumbar spine, 2/23/12, 3/5/12
5. Muscle strength testing, 11/5/12, 8/2/12, 4/19/12
6. Scripts for muscle testing, 11/5/12, 4/19/12, 3/23/12, 8/2/12
7. Notes, 10/29/12, 5/24/12

8. 2/27/12-10/18/12
9. Treatment Order, 10/18/12
10. DWC forms
11. Statement of medical necessity for EMS unit & conductive garment, 10/18/12, 3/23/12
12. Scripts for EMS garment, 10/18/12
13. Electrodiagnostic evaluation, 10/8/12
14. Script for EMG 9/18/12
15. Operative report, 7/18/12
16. Anesthesia record, 6/18/12
17. Script for DME, 5/21/12
18. FCE 4/3/12
19. 3/28/12
20. notes, undated
21. US venous, 3/5/12
22. 12/30/11-1/26/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This individual developed low back pain after assisting. A previous epidural steroid injection has been performed. MRI scan shows L4 through S1 protrusions contacting multiple nerve roots. There is persistent low back and lateral leg pain. EMG study shows peripheral neuropathy but no radicular findings.

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

ODG require objective evidence of radiculopathy. There is no muscle weakness, and the EMG study does not demonstrate radicular findings. ODG are not met for the requested procedure.

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.
- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)