



**INDEPENDENT REVIEW INCORPORATED**

**DATE: 05.27.14**

**Notice of Independent Review**

**DATE NOTICE SENT TO ALL PARTIES: 05/27/14**

**IRO CASE #:**

**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

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

Bilateral L4-L5 transforaminal epidural steroid injections

**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>
724.4	64483		Prosp.				Xx/xx/xx		Upheld
724.4	64484		Prosp.				Xx/xx/xx		Upheld
724.4	77003		Prosp.				Xx/xx/xx		Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY (SUMMARY):**

This claimant sustained a back injury from a fall on xx/xx/xx. He has had lumbar decompression at L3-L4 and L4-L5 and an ACDF in 2003. Six sessions of physical therapy were provided. On 09/20/13, a lumbar epidural steroid injection was performed, which resulted in 40% relief for one month. There was some increased functionality for that period of time.

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

Official Disability Guidelines require 50% to 70% relief for six to eight weeks after an epidural steroid injection to authorize a second one. These criteria are not met. ODG does not endorse a second lumbar epidural steroid injection.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**P. O. Box 787  
 Elgin, TX 78621-0787  
 Phone: 512.218.1114  
 Fax: 512-287-4024**

  
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- 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-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)