

# P-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Feb/20/2014

**IRO CASE #:**

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

Left L4-5 Transforaminal Epidural with Selective nerve block x 3 CPT 64493, 64450

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

Board Certified Orthopedic Surgery  
Fellowship Trained Spine Surgery

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

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

ODG - Official Disability Guidelines & Treatment Guidelines  
MRI of the lumbar spine dated 11/06/13  
Clinical note dated 11/19/13  
Progress note dated 12/13/13, 01/03/14  
Utilization reviews dated 12/02/13, 12/23/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male whose date of injury is xx/xx/xx. The patient bent forward and felt a pressure discomfort that eventually developed into a mild pain and worsened throughout the day. MRI of the lumbar spine dated 11/06/13 revealed at L4-5 there is a broad based 0.5 cm disc herniation with mild loss of disc height partially effacing thecal sac CSF resulting in mild spinal canal stenosis and contributes to mild bilateral neural foraminal narrowing. Note dated 11/19/13 indicates that the patient was given medications and physical therapy that did not improve his symptoms. Follow up note dated 12/13/13 indicates that the lumbar spine has guarded movement that exacerbates on extension and lateral tilt. The lower extremities are neurologically intact with weakness of the left EHL of 4/5 and positive left straight leg raising. There is a negative Patrick's bilaterally.

Initial request for Left L4-5 transforaminal epidural with selective nerve root block x 3 CPT 64493, 64450 was non-certified on 12/02/13 noting that one left L4-5 transforaminal epidural steroid injection would be supported based on the MRI and exam findings, but in light of no

contact for modification, none can be approved. The denial was upheld on appeal dated 12/23/13 noting that current evidence based guidelines do not support a series of three epidural steroid injections. The patient's MRI fails to document any significant neurocompressive pathology.

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

The patient sustained injuries on xx/xx/xx. MRI of the lumbar spine dated 11/06/13 revealed at L4-5 there is a broad based 0.5 cm disc herniation with mild loss of disc height partially effacing thecal sac CSF resulting in mild spinal canal stenosis and contributes to mild bilateral neural foraminal narrowing. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The submitted MRI does not support a diagnosis of radiculopathy. Additionally, the Official Disability Guidelines do not support a series of three epidural steroid injections as subsequent injections are based on patient response to prior injections. As such, it is the opinion of the reviewer that the request for Left L4-5 transforaminal epidural with selective nerve root block x 3 CPT 64493, 64450 is not recommended as medically necessary.

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

- ACOEM-AMERICA 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 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 (PROVIDE A DESCRIPTION)