

**IRO REVIEWER REPORT TEMPLATE -WC**

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**IMED, INC.**

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035  
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584  
e-mail: [imeddallas@msn.com](mailto:imeddallas@msn.com)

**Notice of Independent Review Decision**

**[Date notice sent to all parties]:**

**03/07/2014**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** URGENT  
Appeal Right L4-L5 Transforaminal Epidural Steroid Injection

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

Board Certified PM&R; Board Certified Pain Medicine

**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 of the health care services in dispute.

**IN/FORMATION PROVIDED TO THE IRO FOR REVIEW:**

Clinical note dated 08/20/10  
Clinical note dated 09/02/10  
Clinical note dated 09/16/10  
Clinical note dated 07/01/10  
Clinical note dated 11/05/10  
Clinical note dated 11/12/10  
Clinical note dated 11/22/10  
Clinical note dated 02/13/12

Procedural note dated 02/28/12  
Clinical note dated 01/08/14  
Clinical note dated 01/27/14  
Adverse determinations dated 01/13/14 & 02/13/14

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who reported an injury to her low back. The patient reported injuries to her back, neck, right shoulder, and the right side of her face. The clinical note dated 02/13/12 indicates the patient complaining of intermittent low back pain with radiating pain to the right lower extremity. The note mentions the patient utilizing Hydrocodone, Cyclobenzaprine, and Ibuprofen for pain relief. The patient was recommended for an epidural injection at L4-5 at that time. The procedural note dated 02/28/12 indicates the patient undergoing an L4-5 transforaminal epidural steroid injection. The clinical note dated 01/08/14 indicates the patient complaining of right sided low back pain. The patient reported a reduction in her symptoms following the previous injection. The patient was recommended for a repeat injection at that time. The clinical note dated 01/27/14 mentions the patient reporting no new weakness throughout her extremities. No bowel or bladder incontinence was identified. Intermittent radiating pain was noted from the low back into the lower extremities. The patient also reported intermittent numbness and tingling.

The utilization review dated 01/13/14 resulted in a denial as no information was submitted confirming the patient's radiculopathy in the appropriate distributions.

The utilization review dated 02/13/14 resulted in a denial as no findings consistent with radiculopathy were identified.

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

The documentation indicates the patient having a long history of low back pain. An epidural steroid injection would be indicated in the lumbar region provided the patient meets specific criteria to include ongoing symptomology including a radiculopathy manifested by strength, sensation, or reflex deficits confirmed by clinical exam. No information was submitted confirming the patient's radiculopathy in the L4 or L5 distribution. As such, it is the opinion of this reviewer that the request for a right L4-5 transforaminal epidural steroid injection is not recommended as medically necessary.

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**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 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)**