



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
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**DATE OF REVIEW: 12/02/2015**

**IRO CASE #**

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

Lumbar Epidural Steroid Injection Right L4-5.

**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)

**PATIENT CLINICAL HISTORY [SUMMARY]**

Patient is a female who was injured on the job on XX/XX/XX. Patient was initially diagnosed with lumbosacral sprain/ strain. On 11/4/2014 an MRI was performed on the patient that showed multiple disc desiccation, herniation, and spinal stenosis from L2-3 to L3-4. Also MRI showed a disc herniation at L4-5 to the right. Patient underwent conservative treatment to include P.T. and medication therapy. On 3/23/2015 a right transforaminal was performed that gave the patient 90% relief for one week after which the pain started coming back. After multiple visits the patient continued to complain of low back pain radiating down the right leg VAS ranges from 4-6 to 7-9 at times, patient exhibited poor toe and heel walking, DTRs diminished and positive leg raise test on the right. The patient described the pain to be constant dull, aching, and throbbing in nature. The pain comes and goes.

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

Per ODG references, the requested "Lumbar Epidural Steroid Injection Right L4-5" is medically necessary. After careful review of the chart and specifically the visits after the procedure I believe that a right L4-5 epidural is certifiable. Although the notes did not specify the relief period, from reviewing the notes, patient symptoms improved for a period of about six weeks which satisfies the ODG guidelines, and she continues to have back and radicular component and a positive leg raise test.



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

- 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