

**Independent Resolutions Inc.**  
**An Independent Review Organization**

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**Notice of Independent Review Decision**

Case Number:

Date of Notice: 05/10/2016

**Review Outcome:**

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Anesthesiology And Pain Management

**Description of the service or services in dispute:**

Lumbar ESI Right L4-L5

**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)**

On XX/XX/XX the patient reported low back pain and right hip pain. The pain was worse on standing. The pain was rated 6/10 on VAS. The patient reported symptoms had remained the "same." The range of motion was decreased. There was no radiating pain, numbness or tingling. There was no lower extremity weakness, loss of bowel/bladder control or saddle anesthesia. Physical exam revealed range of motion decreased in all planes. There was no muscle spasm or tenderness. The patient was vascularly intact. Deep tendon reflexes were normal, sensation/muscle strength was normal, sitting straight leg raise was negative bilaterally. Supine straight leg raise was negative bilaterally. Gait was normal. An MRI of the lumbar spine dated XX/XX/XX revealed, L4-5 level posterior 1-2 mm disc protrusion presses on the thecal sac, narrowing the medial aspect of the neural foramen on both sides.

**Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.**

Based on the clinical notes submitted for review, the previous request was denied based on clinical findings were not suggestive of radiculopathy at the requested level. No additional documentation was submitted addressing reason for denial. Based on the documents submitted for review, the requested treatment was not addressed in the most recent clinical note dated XX/XX/XX. A clear rationale was not provided by the physician as to the medical necessity for the request. The physician simply stated on XX/XX/XX, referral to the ESI. Physical exam findings revealed no evidence of patient inability to heel/toe walk. There was no evidence of weakness of knee extension or ankle dorsiflexion. There was no evidence of sensory loss to the medial leg down to the medial surface of the first toe. There was no evidence of diminished patella reflex. Furthermore, there was no indication the patient was instructed in home exercises to do in conjunction with injection therapy as this treatment alone offers no long term functional benefit. Given the lack of documentation, the previous determination is upheld.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- 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 and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical Literature (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)