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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 3/16/15

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Transforaminal ESI (Bilateral) L4-L5 (under Fluorscopic Guidance, Epiduragram) between 1/20/15 and 3/21/15

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Pain Management & Anesthesiology

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	**(Agree) X**
Overturned	(Disagree)
Partially Overturned	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY
Patient is a male who sustained a fall in xx/xxxx and has persistent back and right leg pain. A CT shows a Grade 1 spondylolisthesis at L4-L5 with bilateral Pars defect. There is an L4-L5 disc bulge without impingement. Extensive conservative treatment has been performed including physical therapy, TENS unit and aquatic therapy. Medications have been prescribed. A translaminar lumbar epidural steroid injection was performed on 12/02/14. At a follow up office visit on 1/15/15 it was noted low back and right leg pain that radiates to the top of the foot. 20% pain relief was noted from the ESI. There is increased functionality. Physical exam revealed muscle weakness in the right leg with weak great toe dorsaflexion and decreased deep tendon reflexes. A letter of reconsideration on 1/29 notes 65-70% pain relief.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
Opinion
I agree with the benefit company's decision to deny the requested transforaminal ESI (Bilateral) L4-L5.

Rationale: I agree with the previous reviewer based on ODG recommendations that the criteria are not met for the requested procedure. ODG requires correlation of imaging studies with symptomology. The CT myelogram shows a disc bulge with no impingement.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continuation)
There is no left sided pain documented so a bilateral procedure is not indicated. The office note of 1/15 notes 20% pain relief which does not meet ODG criteria for a second procedure. ODG requires at least 50-70% pain relief for at least 6-8 weeks. These criteria are not met.

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)