Clear Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd. Suite 337-117
Austin, TX 7831

DATE OF REVIEW:
APRIL 13, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Under dispute is the prospective and/or concurrent, medical necessity of lumbar trigger pint injections, left lumbar myoneural injections of left piriformis and left quadratus under anesthesia.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Board-certified Internal 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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Notification of Case Assignment, Medical Records from Requestor, Respondent, Treating Doctor (s), including Dr. (March to November 2006), physical therapy notes, MRI lumbar spine (June 2006), Dr. (July 2006), and Dr. (August 2006 to January 2007).

PATIENT CLINICAL HISTORY [SUMMARY]:
The Patient injured her low back while lifting. MRI showed a bulge at L4-5 and a protrusion at L5-S1. She has been treated with physical therapy, medications, work modifications, and facet and epidural injections with variable success. She

was placed at MMI with a zero percent whole person impairment in July 2006. Dr.'s recent notes document lumbar trigger points as well as piriformis dysfunction.

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

The use of injection therapy for both diagnostic and therapeutic purpose is an accepted form of treatment for chronic low back pain. The treating physician has documented trigger points and muscular dysfunction as a potential pain source. A trial of injections as outlined is reasonable to attempt to treat the Patient's chronic pain.

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)**