

SENT VIA EMAIL OR FAX ON
Oct/12/2009

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

Date of Notice of Decision: Oct/12/2009

DATE OF REVIEW:

Oct/07/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LESI L4/5 and L5/S1

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 8/28/09 and 9/16/09
Dr. 7/13/09 thru 8/24/09
MRI 5/21/09
Radiology Report 4/24/09
Dr. 6/23/09
Dr. 11/14/08 thru 5/7/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man who fell and injured his back on xx/xx/xx. He reportedly has back pain. Dr. described pain in both lower extremities. Dr. noted some sensory deficits in the left L4 to S1 region with positive SLR. Dr. described normal reflexes and sensation. The other examinations reviewed did not describe any neurological losses. The MRI was done on

5/21/09 and reported disc bulges at L4/5 and L5/S1 with mild stenosis at L4/5 and facet changes at L4/5 and L5/S1. The EMG did not show a radiculopathy. This man had an ESI on 8/5/09 that reported on 8/24 as having given 30% relief.

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

This man had the ESI in early August with limited relief. The ODG accepts the role of ESIs when there is radicular pain in a dermatomal pattern. Further, the indication for the ESI on the 8/5 note was for treatment of central stenosis. The ODG has found ESIs to be of limited value in the treatment of symptoms of spinal stenosis. The conditions for approval of the ESI requires the presence of pain in a dermatomal pattern, plus a symptomatic disc herniation on MRI and neurological loss per the AMA Guides (atrophy, abnormal reflexes, abnormal EMG, dermatomal sensory loss). The MRI failed to show a disc herniation. It does not include spinal stenosis as criteria of injections. Therefore, the criteria of an ESI based upon the ODG has not been met.

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

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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