

SENT VIA EMAIL OR FAX ON  
Oct/19/2009

## Pure Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Oct/16/2009

**IRO CASE #:**

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

IDET Lumbar

**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 8/31/09 and 9/18/09  
Pain Consultants 3/23/09 thru 9/8/09  
CT Scan 8/11/09

**PATIENT CLINICAL HISTORY SUMMARY**

This a man who was injured on xx/xx/xx. He was felt to have right L5 pain distribution that Dr. originally felt was either discogenic or facet pain. He did not respond to facet injections. His symptoms are right LS pain with numbness in the right lateral thigh. He has pain with motion and a normal neurological examination. Dr. felt that the CT scan post discogram done on 8/11/09 suggested that the L5/6 disc (sacralization), also called the anomalous facet and disc

in other parts of the chart, could be a pain generator. SI pain was excluded. Apparently Dr. feels that a fusion at L4/5 may be needed if the IDET is not performed or completed.

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

The IDET procedure has been proposed and used as an alternative to spinal fusions in the treatment of discogenic pain. The ODG, based upon evidence-based medicine, does not support the use of the procedure. Further, the Reviewer went to the American Pain Society Guidelines that did not support its use. The ODG did note that some other guidelines note some limited improvement with the procedure. Other areas of concern are the less satisfactory outcomes in Workers' Compensation patients. Further, the ODG has criteria that are to be met if the procedure is to be done anyway. There are MRI features, the presence of concordant pain on the discogram and a role for a psychological screen. The Reviewer did not see that the Discogram caused the concordant pain per Dr. post discogram CT. Perhaps it did, but the Reviewer does not have that report or the advised psychological screens. Therefore, the Reviewer cannot overturn the prior decisions against the procedure.

“There is insufficient (poor) evidence from randomized trials...to reliably evaluate ...IDET...” **“Chou, Intervential therapies of Low Back Pain. A Review of the Evidence for an American Pain society Cliical Practice Guideline.”** Spine 1089 May 1 200-“ 34: 1085, 1089

**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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)