

SENT VIA EMAIL OR FAX ON
Oct/19/2009

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Second ESI @ C6-7

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 9/17/09 and 9/28/09
FOL 10/2/09
Dr. 3/27/09 thru 8/29/09
Dr. 7/8/09
Dr. 7/8/09
Dr. 8/17/09
Hospital 5/11/05
Family Practice 5/27/09 thru 6/1/09
Radiology Reports 3/6/09
Dr. 7/14/09

Dr. 8/24/09

PATIENT CLINICAL HISTORY SUMMARY

This man was injured on xx/xx/xx and initially complained of neck and left upper extremity pain and subsequently right upper extremity pain (Dr.). An MRI done on 5/28/09 showed a 2-3mm right-sided disc herniation at C4/5 without nerve root compromise. An EMG done on 7/16/09 was interpreted as showing a bilateral C5/6 radiculopathy. The Reviewer could not read the column headings, but the Reviewer presumes from the narrative, that this showed spontaneous activity in the cited muscles.

There are several physical examinations. Dr. on 8/17, as a Designated Doctor, commented upon the left shoulder pain, but found no specific motor or sensory abnormalities other than a left C5/6 sensory deficit. Dr. described glove like sensory abnormalities in the right hand, but the left upper extremity was normal. Dr. has numerous reports from March through August that described no specific neurological abnormalities other than fluctuating grasp. Dr. and Dr. described some left C5/6 sensory loss. The multiple examiners described symmetrical, although sometimes reduced, reflexes. He had a cervical ESI on 8/18/09 with less than a week's relief per Dr. and 2 days per Dr.

Cervical xrays showed a suggestion of a possible old spinous process fracture.

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

The multiple examiners did describe sensory deficits on the left side at C5/6. The MRI showed a right disc protrusion. The ODG requires the clinical and radiological and or electrodiagnostic studies. The problem is the MRI shows a right sided disc protrusion and the complaints are greater on the left. Second, the person had 2-7 days of relief, based on the physician reports. The ODG states that "(7—see below) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks..." This was not accomplished. Therefore, there is no justification for the repeat ESI.

(7) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.

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)