

Pure Resolutions Inc.

An Independent Review Organization
1124 N Fielder Rd, #179
Arlington, TX 76012
Phone: (817) 349-6420
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/25/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Transforaminal Lumbar ESI L5/S1 under Fluroscopy and Iv Sedation

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 9/3/09 and 8/18/09

Dr. Letter 8/19/09

3/12/09 thru 8/19/09

MRI 3/6/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured on xx/xx/xx. He had a distant history of back problems and cervical fusion, but was asymptomatic at the time of the injury. The records describe his pain and numbness with tingling in both lower extremities. The examination cited limited lumbar motion with tenderness and positive SLR and slump test. He had an EMG on 7/9/09 that showed no radiculopathy. His MRI showed grade I L5/S1 anterolithesis with facet degeneration and moderate canal and foraminal stenosis bilaterally. He failed to improve with PT. He had unrelated iliotibial band syndrome.

Exam rstricted motin.
Dr. SLR and slump test.

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

Epidural injections are permitted for the treatment or radicular pain and objective evidence of a radiculopathy. This man had complaints in his back and both lower extremities. There were no specific dermatomes identified. There is some spinal stenosis, but the question exists if ESIs help. There was no evidence of nerve root compression on the MRI or on the EMG. There was no description of dermatomal sensory loss, measurable muscle atrophy or abnormal (asymmetrical) reflexes as required by the ODG and the AMA Guides. Therefore, the request is not medically necessary.

ODG

Epidural steroid injections (ESIs), therapeutic
Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition.

(1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#))

The AMA Guides

“Radiculopathy

Radiculopathy for the purposes of the Guides is defined as significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness, and/or paresthasias in a dermatomal distribution. The diagnosis of herniated disc must be substantiated by an appropriate finding on the imaging study. The presence of findings on a imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be evidence as described above. “

“Atrophy

Atrophy is measured with a tape measure at identical levels on both limbs. For reasons or reproducibility, the difference in circumference should be 2cm or greater in the thigh and 1cm or greater in the arm, forearm, or leg...”

Page 382-382. AMA Guides to the Evaluation of Permanent Impairment. 5th edition

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)

Page 382-382. AMA Guides to the Evaluation of Permanent Impairment. 5th edition

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