

SENT VIA EMAIL OR FAX ON
Jan/18/2010

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

Corrected Amended 1/20/10 (Review Outcome)
Date of Notice of Decision: Jan/18/2010

DATE OF REVIEW:
Jan/18/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Transforaminal ESI left L4-L5

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 12/11/09 and 11/19/09
Dr. 11/9/09 thru 1/5/09
MRI 12/1/09
Dr. 11/24/09
OP Report 7/28/09
Neurological Exam 8/3/09
Dr. 7/2/09 thru 10/23/09
Medication Page No Date

PATIENT CLINICAL HISTORY SUMMARY

This is a xx - injured xx/xx. He had ongoing back pain. He underwent a discectomy in 7/09, but apparently had ongoing pain. An MRI in December 2009 showed the partial discectomy and bulge at L5/S1 with bilateral neuroforaminal narrowing. The EMG did not demonstrate any abnormalities. The paraspinals were not examined presumably due to the recent surgery. He has ongoing pain. The examination reported local pain, limited motion and symmetrical reflexes.

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

The request for the ESI is for the failed back syndrome. The examination is for pain. The reviewer could not determine in the postoperative examinations if the pain fell into a specific dermatomal pattern. That is required by the ODG. The 11/09/09 note is the most detailed, but the reviewer could not reconstruct a dermatomal pattern from the description. Radiological findings alone do not suffice. The reflexes were symmetrical. The reviewer could not decipher any sensory deficit from the way the note was written. In the absence of the required dermatomal distribution, **the reviewer agrees with the URA reviewers.**

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)