

SENT VIA EMAIL OR FAX ON
Dec/21/2009

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/18/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Lumbar Transforaminal ESI 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 11/13/09 and 11/23/09

Pain & Wellness 3/12/09 thru 11/9/09

OP Reports 9/16/09 and 7/10/09 thru 10/22/02

10/4/02 thru 12/27/02

Dr. 10/13/08 thru 2/11/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured in xxxx. His radiological studies showed spinal stenosis with L4/5 root compromise. He had ESIs in xxxx. He underwent a L4/5 laminectomy in 2002. He has ongoing pain. Facet injections were not very successful in September 2009. There are no recent radiological studies although an MRI was requested. Dr. noted back pain and lower extremity pain and paresthesias. He wrote on 11/9/09 of "pain in his right L5 and S1 distribution. Dr. wants to perform a transforaminal ESI on the left at L5/S1.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The ODG recognizes the role for pain relief with ESIs. It has criteria based upon evidence-based medicine. This requires the documentation of a radiculopathy per the ODG and the AMA Guides Criteria. First there has to be an evidence of symptoms in a dermatomal distribution. Dr. wrote of right-sided symptoms in the L5/S1 distribution, but wants to perform a left sided transforaminal ESI. This does not describe a specific radiculopathy. Further, there was no description of any neurological abnormalities such as asymmetrical reflexes, atrophy, motor or sensory loss, abnormal EMG, or radiological findings etc. as described in the AMA Guides. Therefore the documentation of a radiculopathy has not been made by the ODG criteria.

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)