

I-Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 62311 Lumbar Epidural Steroid Injection #1 at L5-S1, 64483 Addtl Level; 77003 Fluoroscopic Guidance

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists

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

Adverse Determination Letters, 10/27/09, 11/12/09

ODG Guidelines and Treatment Guidelines

Pain Consultant 10/27/09, 10/16/09

Pars Open MRI 4/21/08, 3/27/08

Claims 12/17/09

Associate Statement 3/27/08

Work Status Report 3/21/08, 4/16/08, 4/28/08, 6/12/08, 8/18/08, 9/22/08, 10/22/08, 11/19/08, 12/17/08, 2/4/09, 3/4/09, 4/8/09, 5/6/09, 5/26/09, 6/3/09, 7/7/09, 7/21/09, 8/5/09, 9/2/09, 9/3/09

Clinic Visit Note 3/27/08

Request for care 3/27/08

Job Offer 3/28/08

Dr. MD 4/16/08, 4/28/08, 5/29/08, 8/18/08, 10/22/08, 11/19/08, 12/17/08, 1/6/09, 2/4/09, 3/4/09, 4/8/09, 5/6/09, 6/3/09, 7/6/09, 8/5/09, 9/2/09

Occupational Healthcare 6/12/08, 7/30/08, 9/22/08

MD 6/16/08, 6/24/08, 7/1/08, 7/2/08, 7/14/08, 7/24/08, 12/29/08, 1/29/09

CBO 7/7/08, 7/11/08, 7/24/08, 7/31/08, 8/6/08, 12/30/08

Methodist Hospital 8/25/08

Report of Medical Evaluation 11/20/08, 9/2/09, 10/1/09, 11/23/09

MD 11/20/08

Orthopaedic 3/24/09, 5/26/09, 7/21/09

RS Medical 6/2/09

8/5/09, 8/26/09, 9/8/09, 9/4/09, 9/23/09, 11/12/09, 10/27/09

Injury Center 9/3/09, 9/16/09

D.C. 10/1/09

Mobile Kinetics 10/1/09, 10/23/09

PATIENT CLINICAL HISTORY SUMMARY

This patient complains of low back pain that radiates into the left lower extremity. The patient has an MRI that shows a left paracentral herniation with an annular tear at L5-S1. The patient has failed physical therapy and medication management. Physical exam is significant for “patchy dysesthetic area extending from the posterior aspect of buttock into the lateral aspect of the calf with a numb region in the lateral aspect of the right foot.”

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

Per the ODG, “Objective findings (of radiculopathy) on examination need to be present.” The patient’s symptoms are on the left, but the physical exam findings are on the right. There are no objective findings noted for radiculopathy on the left. Therefore, this request does not meet the ODG criteria for ESI. The reviewer upholds the previous adverse determinations. The reviewer finds that medical necessity does not exist for 62311 Lumbar Epidural Steroid Injection #1 at L5-S1, 64483 Addtl Level; 77003 Fluoroscopic Guidance.

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)