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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 07/20/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

A bilateral ESI with fluoroscopy at L4-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified in Orthopedic 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

A bilateral ESI with fluoroscopy at L4-S1 – Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY

On xxxxx, Dr. diagnosed the claimant with hypertension, obstructive sleep apnea, palpitations, a murmur, chest pain, hyperlipidemia, and obesity and medications included Bisoprolol, Aspirin, and Lipitor. On xxxx, Dr. felt the hypertension, hyperlipidemia, and obstructive sleep apnea were diseases of life and were exacerbated by obesity. He felt the medications to treat those conditions were also not related to the compensable injury. In regards to the hypertension, dyslipidemia, obstructive sleep apnea, upper airway resistance syndrome, and periodic limb movement disorders of sleep, Dr. felt the compensable work related injury and subsequent operative procedure did not relate to or affect those diagnoses and again felt they were diseases of life. X-rays of the lumbar spine interpreted by Dr. on 10/12/09 showed postoperative changes at L4-L5 and L5-S1 with a solid fusion and mild degenerative disc space narrowing at L3-L4 with moderate degenerative disc space narrowing at L2-L3

and L1-L2. A CT scan of the lumbar spine on 11/17/09 interpreted by Dr. showed the prior surgeries at L4-L5 and L5-S1, with mild degenerative changes at L2-L3 and tight spinal stenosis at L3-L4. A bilateral lumbar ESI was performed by Dr. Schocket on 02/09/10. On 05/24/10, Dr. recommended yoga and a repeat lumbar ESI. On 06/03/10, Dr. provided an authorization request form for a lumbar ESI. On 06/07/10, Mr. recommended physical therapy twice a week for four weeks. On 06/08/10, Dr. wrote a letter of non-certification, according to the ODG, for bilateral L4-S1 ESIs. On 06/15/10, Dr. wrote a reconsideration letter for six sessions of physical therapy. On 06/16/10, Dr. wrote a letter of non-certification for the lumbar ESIs, according to the ODG. On 06/22/10, Dr. wrote a letter of appeal for the lumbar ESIs.

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

The bilateral ESI with fluoroscopy bilaterally at L4 to S1 is neither reasonable nor necessary. The patient does not have objective signs of radiculopathy as indicated in the ODG. There are no motor or sensory changes. An EMG itself is not objective findings of radiculopathy, but the argument by the treating provider that an EMG has not been allowed does not change whether there is radiculopathy or not. The patient has not participated in physical therapy. The patient has been instructed by his prior treating providers not to perform any activities and to lead a sedentary lifestyle. The current medical research indicates that this is neither reasonable nor necessary and before proceeding with ESIs, the patient should participate in physical therapy. Further, the medical records do not document any significant response from the initial ESI. Retrospectively, the patient states he did receive relief, but that is not documented by the contemporaneous medical records provided. The patient does not meet the criteria set forth by the ODG for repeat ESIs at L4-L5 or L5-S1. Therefore, the requested bilateral ESI with fluoroscopy at L4-S1 is not reasonable nor necessary and the previous adverse determinations should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE
- 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)