

SENT VIA EMAIL OR FAX ON
Jun/24/2010

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left PSOAS Block with Fluoroscopy

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 6/2/10 and 5/14/10

Pain 10/7/09 thru 5/21/10; OP Reports 3/29/10 and 12/31/09

Clinic 1/7/10

PATIENT CLINICAL HISTORY SUMMARY

This man was injured in xxxx. He apparently had ongoing pain and a spinal cord stimulator implanted in 2003. He had 4 months of 80% relief following a left psoas block in 12/09, and 80% relief after the 4/20/10 right psoas block. The left lower extremity pain recurred and a repeat left psoas block was requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

This is discussed in the hip/pelvis section of the ODG and referred to the piriformis injection section. The IRO Reviewer is not clear from reading the notes from Dr. why he chose to advise the psoas block. The history and physical described back and buttock pain. The man did improve with the injection. The ODG does not describe a frequency for the invasive treatment. It does approve it as an option after PT. The IRO reviewer did not see that he had therapy in the 2009 notes provided. At the same time, the IRO reviewer is not sure if the therapy would have been approved per the ODG criteria for the hip or spine. Since it provided relief and can be a recommended treatment option, the IRO reviewers medical assessment is that the request is medically necessary.

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)