

SENT VIA EMAIL OR FAX ON
Jun/22/2010

Applied Resolutions LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/21/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Transforaminal ESI L4/5 Bilaterally

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

Board Certified Orthopedic Surgeon

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

PT note, 10/06/09, 11/04/09, 12/09

Progress Note, 10/13/09, 10/29/09, 11/25/09, 12/18/09, 01/08/10, 05/10/10

Office notes, Dr., 01/21/10, 02/18/10, 04/09/10, 05/06/10

MRI thoracic spine, 02/09/10

MRI lumbar spine, 02/09/10

Coventry peer review, 04/23/10

Attorney letter, 06/07/10

Physical Therapy Hand Written, 10/07/09, 10/09/09, 10/08/09, 10/12/09, 10/14/09, 10/19/09, 10/22/09, 10/23/09, 10/26/09, 10/28/09, 11/02/09, 11/03/09, 11/11/09, 02/23/10, 02/24/10, 02/28/10, 02/26/10, 03/01/10, 03/02/10, 03/03/10, 03/04/10, 03/11/10, 03/12/10, 03/16/10, 03/18/10, 03/22/10

Progress Note, 11/12/09, 03/08/10

Laboratory Reports, 2010

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a window glazer injured apparently on xx/xx/xx when he was electrocuted and fell off a ladder.

He was seen initially for thoracic spine pain and treated with pain medication and therapy. He then developed lumbar pain that did not respond to therapy.

On 01/21/10 Dr., evaluated the claimant for back and thoracic pain. The examination documented reflexes at 2/4+ and normal strength. Facet loading was positive and was worse

with extension. Straight leg raise caused back pain. Tenderness was noted at T6. The impression was posttraumatic back and thoracic spine pain. Recommendations were for an MRI, Norco, Flexeril and Celebrex.

A 02/09/10 MRI of the thoracic spine was negative. The 02/09/10 MRI of the lumbar spine documented L4-5 disc desiccation with an annular bulge and tear; there was no herniation and no foraminal narrowing or spinal stenosis. At L5-S1 was disc desiccation and mild loss of disc height; a small disc bulge with annular tear; no herniation, foraminal stenosis or central stenosis.

The claimant was prescribed medications and additional therapy. On 04/09/10, Dr. noted the presence of severe back pain. Therapy had been discontinued. No orthopedic examination was documented. Dr. recommended a transformational steroid injection at L4-5 for back pain syndrome. This was denied on two occasions.

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

Epidural steroid injection is not medically indicated and appropriate in this male who was electrocuted causing him to fall on xx/xx/xx. The records reflect that he has axial spine symptomatology, but no radicular complaint associated with this.

A 02/09/10 MRI of the thoracic and lumbar spine were reviewed; the thoracic study was negative and the lumbar study was negative for herniation, foraminal narrowing, or stenosis. Based upon these findings, which are absent for clinical evidence of a radiculopathy, epidural steroids are not indicated and appropriate. This is consistent with guidelines.

Official Disability Guidelines 2010, 15th Edition-Low Back
Epidural Steroid Injection

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)