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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/14/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L-ESI @ L4-5 L5-S1 with Fluoro 62311 (PNR 72275 77003) & Post Injection PT x 9

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

MD, Board Certified in Physical Medicine and Rehabilitation

Board Certified in Electrodiagnostic Medicine

Board Certified in Pain Management

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

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured when he fell onto his buttocks on x/x/xx. He had an MRI on 5/21/09 that noted mild L4/5 stenosis with a mild left L5/S1 disc bulge and facet degeneration in the low back. There was a normal electrodiagnostic study by Dr. in 6/09. He had an ESI on 8/5/09. The note dated 8/24/09 stated that at 3 weeks he had "improved 30%. A second ESI was requested. In the letter of necessity dated 4/21/10, Dr. has written that the patient had low back and buttock and coccyx pain. On 4/5/10, Dr.'s notes state that: "He denies any radiating pain signs and symptoms to his extremities."

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

The ODG will recommend the use of an ESI if there is radicular pain in a dermatomal distribution. This key criteria was not met in this patient's case. Further, ODG requires corroboration of findings with the radiological report, neurological findings or abnormal electrodiagnostic testing. These criteria were not met either. According to ODG, ESIs are not

generally useful for spinal stenosis. Repeat blocks are considered when there is more than 50% relief for more than 6 weeks. This criteria was not met. In addition, the ODG recommends 1 or 2 PT sessions after an ESI. In this case 9 sessions have been requested which exceeds the guideline recommendation. There was no explanation provided that would justify a variance from the ODG. The reviewer finds that medical necessity does not exist for L-ESI @ L4-5 L5-S1 with Fluoro 62311 (PNR 72275 77003) & Post Injection PT x 9.

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)

Page 382, AMA Guides to the Evaluation of Permanent Impairment. 5th edition