

SENT VIA EMAIL OR FAX ON  
May/18/2010

## P-IRO Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

May/18/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Outpatient Bilateral S1 transforaminal ESI.

**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 4/23/10 and 5/4/10

RM 4/14/08

Pain 12/16/08 thru 4/20/10

Ortho 8/18/08 thru 4/12/10

Spine and Joint 10/21/08 thru 4/22/10-MRI

**PATIENT CLINICAL HISTORY SUMMARY**

This lady fell in xxxx. The records stated she had a fusion about 2002. She had an increase of pain after an MVA in 2004. The peer review noted the presence of a neuropathy in 1999/2000. There was no report of a radiculopathy on a 1999 EMG cited in the records. She had several months of relief with an RF rhizotomy. The pain recurred. Her MRI on 4/16/10 showed degenerative changes at L4/5 and L5/S1. Dr. described bilateral pain in the back and back of the legs. Dr. felt it was in the S1 dermatome, especially on the right. She had bilateral weakness and normal reflexes. Dr. felt her symptoms were in the right L5 dermatome. All agreed reflexes were normal.

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

The ODG accepts ESIs for the management of radicular pain, but not for chronic pain. There must be a dermatomal distribution of the pain. Dr. and Dr. gave conflicting ones, but there is overlap. There must also be neurological, radiological or electrodiagnostic findings per the AMA guides. There was no recent EMG. The MRI did not describe nerve root compromise. There was symmetrical motor or sensory complaints that could reflect the prior back surgery or neuropathy. There, based on a careful review of all medical records, the IRO reviewer's medical assessment is that the request is not 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)