

SENT VIA EMAIL OR FAX ON
May/26/2010

Pure Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/24/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Bilateral Transforminal Epidural Steroid Injection L4/5, L5/S1 with one Physical Therapy Visit

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 4/7/10 and 5/6/10
Pain Solutions 1/2/09 thru 4/13/10
5/11/10
Imaging 4/4/07
Dr. 12/29/08

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured in xxxx and subsequently underwent an L5/S1 fusion. I am not clear of the date. He has failed back syndrome. He reportedly had a caudal ESI done on 10/31/08. The most recent note after that date was by Dr. on 1/2/09 requesting a second caudal ESI.

This was denied. A bilateral transforaminal ESI at L4/5 and L5/S1 were requested. He reported this man as having a radiculopathy and burning in the feet. The right knee and ankle jerks were 1+ and the left were 2+ until the 4/13/10 note where the bilateral knee jerks were reduced and the ankle jerks were absent. The strength was generally 4+ bilaterally. There was 30 degrees of bilateral positive SLR. Dr. noted reduced sensation bilaterally in the L5/S1 dermatomes. He had reported 8 hours of relief with intrathecal morphine in 5/09. A pump was mentioned, but was not discussed further. The CT myelogram showed a 4mm posterior protrusion at L4/5 with the L5/S1 fusion.

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

There are several factors to be considered. First, the ODG requires that the pain be in a dermatomal pattern. Dr. did not describe that key requirement in any of the reports. He said the man had a radiculopathy. There was the described reflex asymmetry that changed in the most recent note. The ODG requires a period of symptom free interval before repeating the study. The therapeutic ESI section requires 6-8 weeks of at least 50% relief. The IRO reviewer did not see a follow up report after the 10/31/08 ESI until the note on 1/2/09 that he needed a second one. This is just short of 9 weeks, and would suggest that the man did not demonstrate the required relief prior to a repeat procedure. The ODG does not permit more than 2 transforaminal levels at a time. Four were requested, 2 bilateral. This however is more for diagnostic than therapeutic purposes. For these reasons, the request did not meet the requirements of the ODG for medical necessity.

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)