SENT VIA EMAIL OR FAX ON
Mar/03/2010

IRO Express Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/25/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar ESI #1 under Anesthesia Fluoro Guidance

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:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 1/12/10 and 1/29/10
Dr. 12/16/09 thru 2/8/10
Pain Relief 7/20/09 and 10/27/09
MRI 10/14/09
EMG/NCV 12/11/09

PATIENT CLINICAL HISTORY SUMMARY
man injured was reportedly injured on xx/xx/xx. Dr. and other doctors described pain down both legs, generally above the knees, with bilaterally positive SLR. The MRI showed a small L4/5 bulge, but a larger subligamentous central HNP at L5/S1. His examination showed no reflex abnormalities. The EMG was intepreted as being abnormal by showing some fibrillations and insertional activity increase in the Abductor Hallucis and medial gastrocnemius. The report also described the Abductor Hallucis as normal.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The ODG approves the use of ESIs in the treatment of radiculopathy, and not just radicular pain. Both the ODG and the AMA Guides require that the pain be in a dermatomal distribution. Dr. wrote that the pain was radicular, but did not clarify the root distribution. The presence of a herniated disc on MRI alone is not sufficient. The abnormal EMG pattern supports the diagnosis once the dermatomal pattern is identified. The reports consistently said this man had radicular pain, but no one described a specific dermatomal pattern. Rather, it was described as being posterior above the knees on one occasion and to the feet on other reports. This is a requirement repeated several times. The man had no specific reflex abnormalities. There were comments of both normal and abnormal sensory findings. Without the required dermatomal description, 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)