

SENT VIA EMAIL OR FAX ON
Feb/16/2010

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

outpatient lumbar 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 1/7/10 and 1/25/10
Pain 3/23/09 thru 1/4/10
OP Report 6/5/09 and 4/2/09
Chest 2 views 5/26/09

PATIENT CLINICAL HISTORY SUMMARY

This man was injured in xxxx. The medical records report a spinal cord stimulator in place, but Dr. treats this as a pump. He had performed trigger point injections on multiple occasions and wished to perform an ESI at this time.

On 1/4/10, Dr. wrote that this man has a radiculopathy. His documenttion was the burning and shooting pain in the lower extremities.

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

Dr. states that this man has a radiculopathy based upon the burning and shooting pain in the lower extremities. He may in fact have a radiculopathy, but it is not documented to the criteria of the ODG.

First, the ODG requires the presence of a radicular pain as one component of a radiculopathy. The radicular pain must be in a dermatomal pattern. Dr. only described

generalized lower extremity shooting and burning pain. The ODG relies on the AMA Guides 5th edition for a description of a radiculopathy. This also relies on the radicular pain along a dermatome, plus abnormal neurological findings and radiological findings. The reviewer did not find the radiological reports. An MRI could not be performed with the stimulator or pump in place. Further, there was no description of any neurological abnormalities. The incision was described as was the local lumbar region and the trigger points. Further, The value of ESI for chronic pain is limited per the ODG. In the absence of a documented radiculopathy, the request does not justify the procedure per the ODG criteria.

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)