

SENT VIA EMAIL OR FAX ON
Nov/03/2010

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/01/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LESI with fluoro under anesthesia; MAC anesthesia

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 8/18/10 and 9/13/10
10/18/10
MRI 7/10/09
Dr. 6/17/09
Dr. 3/11/10 thru 10/7/10
DDE 9/12/09
Dr. 6/18/10
Dr. 4/23/10
Dr. 7/16/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured on xx/xx/xx. She reportedly developed back and left leg pain pushing a cart. The MRI 7/4/09 showed L4/5 and L5/S1 without root compression. There is facet hypertrophy. Dr. physical exam on 6/17/09 did not show any neurological loss with normal sensory and motor exam. The electrodiagnostic study was normal. Dr. saw her on 7/16/09 and felt she had a radiculitis. Dr. performed a DD exam on 9/12/09 and found a normal examination without neurological abnormalities or atrophy. She gave this lady a 0% impairment rating. Dr. saw her on 4/23/10 and found painful motion, but no neurological deficits.

Dr. saw her on 6/18/10 examined her and found no neurological deficit, but advised an ESI for the pain.

Dr. /Dr. reports of 3/11/10, 4/8/10, 6/3/10, 7/7/10 and 10/7/10 described pain; the neurological exam was normal with normal sensation, reflexes and motor exam. The SLR is normal. He planned a lumbar epidural injection for the diagnosis of a "Lumbar herniated disk." The note from Ms and Dr. on 8/12/10 and 9/9/10 did not demonstrate any neurological loss.

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

The lady has back pain with left leg pain. Multiple doctors failed to document any neurological loss consistent with a radiculopathy. Her pain is down the left leg. Dr. stated she has a radiculitis. Dr. wrote in his letter of 9/2/10 that she had "evidence of lumbar herniated disk and radiculopathy in the L5 and S1 dermatomes."

The ODG allows for the use of ESIs for the treatment of radiculopathy. It requires that the "pain (be) in dermatomal distribution with corroborative findings of radiculopathy." The latter is based upon the AMA guides. This requires the presence of objective findings plus the subjective symptom complaints of a dermatomal distribution of the pain. Radiological findings alone are not sufficient. Dr., Dr., Dr., Dr. Dr. and even Dr. and his associates did not describe any neurological loss. The AMA guides describe these are weakness, atrophy, sensory loss or abnormal emgs. In the absence of these objective findings, one cannot document a radiculopathy and therefore cannot establish the medical necessity based upon 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)