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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: October 4, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bil Transforaminal ESI L1 64483 77003

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

MD, Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management

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

Denial Letters 8/23/10, 9/7/10
Back Institute 8/2/07 to 8/12/10
Imaging 1/15/07, 11/29/06, 1/30/08
Express 11/1/06 to 12/26/06
11/6/06 to 2/8/07
Medical Clinic 1/15/07 to 2/12/07
M.D. 2/22/07 to 4/30/08
Surgery Center 4/12/07 to 5/15/07
Solutions 7/18/07
8/28/07, 11/12/07
3/13/08
6/24/08
Systems 7/3/08 to 5/06/10
Hospital 7/13/09 to 3/30/10
Hospital 11/3/09
ODG-TWC

PATIENT CLINICAL HISTORY SUMMARY

This woman reportedly twisted her back stepping off a stool on xx/xx/xx. Her initial MRI (11/06) showed multiple level disc bulges in the lumbar spine and an L1/2 herniation and degeneration, but no nerve root compromise. Dr. commented about a second MRI done in 7/09 that showed the degeneration, but also a left lateral herniation at L4/5 not previously described. Both studies showed facet problems. She reportedly had back pain without radiation as described by Dr. and Dr.. Multiple examinations stated there was no radiation of the pain, and no neurological loss. Notes describe local lumbar tenderness and limited lumbar motion. Provider noted she had limited benefits from a prior ESI and facet rhizotomy. Dr. ordered an L1 ESI in his 9/14/09 note. His 10/26/09 note described "good relief" after an L1/2 transforaminal ESI and planned to repeat it. It gave better relief. Dr. agreed (12/15/09) to repeat the ESI. He noted 50% relief for up to 2 months after a 12/09 injection. He felt another was justified. That was performed on 3/30/09 with 50% relief.

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

Both Dr. and Dr. felt the patient had discogenic pain. There was no neurological loss. Dr. wrote on 4/9/10 that she has "Chronic low back pain syndrome with lumbar disk derangement and disk herniation at multiple levels." He wrote on 8/12/10 "The patient has chronic low back pain with significant findings on the MRI." The ODG only justifies the use of ESI for the treatment of radicular pain (in a dermatome). Both Dr. and Dr. specifically noted no radicular pain. ODG also requires "corroborative findings" that include abnormal neurological findings or electrodiagnostic findings as described in the AMA Guides. These were not found. Further the AMA Guides state "The presence of findings on a imaging study in and of itself does not make the diagnosis of radiculopathy." The radiological studies and her symptoms are the basis for the current treatment. While the ODG does accept a role of therapeutic ESIs, which appears to be the intent here, it still requires the presence of a radiculopathy. Without meeting this requirement, the medical necessity of the injections has not been justified and the guidelines have not been satisfied. The reviewer finds that medical necessity does not exist for Bil Transforaminal ESI L1 64483 77003.

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)