

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 8/25/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal: Lumbar ESI L5-S1 62311

QUALIFICATIONS OF THE REVIEWER:

Physical Med & Rehab, 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)

Appeal: Lumbar ESI L5-S1 62311 Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Case assignment, dated 8/5/2010
2. Review organization by Author unknown, dated 8/2/2010
3. Letter by MD, dated 7/27/2010
4. Notification of determination by, dated 6/25/2010
5. Independent review organization by Author unknown, dated unknown,
6. Official Disability Guidelines (ODG)
7. Case assignment by, dated 8/5/2010
8. Review organization by Author unknown, dated 8/2/2010
9. Letter by MD, dated 7/27/2010
10. Notification of determination by, dated 6/25/2010
11. Independent review organization by Author unknown, dated unknown,
12. Official Disability Guidelines (ODG)
13. Letter by, dated 8/9/2010
14. Disability duration guidelines dated 8/5/2010
15. Independent review organization by author unknown dated 8/2/2010
16. Letter by MD dated 7/27/2010
17. Face sheet by author unknown dated 7/19/2010
18. Letter by DO dated 6/25/2010
19. Worker compensation authorization form by author unknown dated 6/1/2010
20. Letter by MD dated 3/8/2010

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21. Letter by MD dated 2/9/2010
22. History note by MD dated 9/29/2009 to 7/19/2010
23. Operative report by MD dated 9/28/2009
24. Prior peer review by MD dated 5/21/2009
25. Lab report by author unknown dated 3/22/2006 to 5/11/2009
26. Updated peer review by MD dated 9/26/2007 & 5/6/2009
27. Review of symptoms by author unknown dated 2/13/2006
28. MRI of the lumbar spine with and without contrast by MD dated 7/19/2005
29. MRI of the lumbar spine without and with intravenous by MD dated 7/19/2005
30. Prescription note by author unknown dated 7/18/2005
31. History form by author unknown dated 8/31/2004
32. Description of services by author unknown dated 6/17/2004
33. Fax page dated 6/17/2004
34. Letter of medical necessity by MD dated 6/4/2004
35. Letter by author unknown dated 4/27/2004
36. Supply order by author unknown dated 4/14/2004
37. Function capacity assessment by DC dated 3/31/2004
38. Status report by author unknown dated 3/30/2004
39. Medical examination by MD dated 3/30/2004 & 10/5/2005
40. History note by DC dated 2/17/2004
41. Operative note by MD dated 9/18/2003
42. Impairment and functional evaluations by DC dated 3/31/2004
43. Patient daily notes dated 9/30/2003 to 9/15/2004
44. Note by MD dated 8/25/2003 to 8/3/2009
45. Review organization by author unknown dated unknown
46. Statement of medical necessity by author unknown dated unknown
47. Treatment recommendations by author unknown dated unknown

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male with lumbar disc disease under IRO for request of lumbar ESI L5/S1. Date of injury is xx/xx/xx. The employee has a history of lumbar fusion and copious other conservative treatments. The employee has pain in the back and down legs, right greater than left. He takes hydrocodone which helps, previously took Neurontin. On exam he has decreased strength in the right leg, positive straight leg raise on the right and decreased sensation in the feet. Diagnosis is lumbar disc disease with increased radicular pain. Relief from injections is noted to last about 4 months. Weaning of hydrocodone is recommended. Spinal cord stimulator is another option beyond ESI. The injured employee may have non-work related peripheral neuropathy of diabetes. Office encounter 7.19.10 notes 60-70% pain relief from prior ESI with functional improvement last 4 months after left L4 and L5 transforaminal ESI on 9.28.09. Office visit on 12.08.09 notes pain decrease of 9/10 to 2-3/10 from the injection. Office visit on 3.15.10 notes increasing pain level 5-6/10. Lumbar MRI scan 10/27/08 demonstrates degenerative spondylosis in the lumbar spine from L2-S1 with a large paracentral disc protrusion at L2-3, severe spinal stenosis noted at L2-3, post-operative changes at L3-4, L4-5, and L5-S1, and severe spinal stenosis at L4-5, mild central stenosis at L3-4.

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

The injured employee meets ODG criteria for repeat therapeutic ESI. The injured employee has chronic lumbar radiculopathy status post lumbar fusion. The injured employee has had copious amounts of traditional conservative measures over the number of years since injury yet the injured employee has continued chronic radiculopathy. Prior therapeutic left L4 and left L5 TFESI on 9.29.09 has provided documented 60-70% pain relief of reported pain scores of 9/10 to 2-3/10 greater than 2 months after procedure per the 12.8.09 office note. Functional improvement is clearly documented in the subsequent office encounters per ODG requirements. Now the injured employee has exacerbation of chronic radiculopathy and repeat injection is requested and warranted per the guideline criteria which are met. The relevant guideline criteria are numbers 1, 2, 3, 5, 7 and 8. Numbers 4, 9 and 10 are not applicable to the request.

According to the records submitted the injured employee received 60-70% pain relief lasting 4 months. Criteria were met.

According to the records the injured employee received 60-70% pain relief lasting 4 months from left L4 and L5 TFESI on 9.28.09. There are copious records now provided which reveals a lumbar fusion 11/2000. The injured employee has tried physical therapy, medication management and surgery with continued findings of chronic radiculopathy and related subjective complaints. Criteria were met.

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Thus, the recommendation is to overturn the previous denial.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)