

SENT VIA EMAIL OR FAX ON
Sep/17/2010

Applied Resolutions LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/17/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection #2 and #3

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

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 7/9/10 and 7/28/10

Dr. 4/26/10

NCV/EMG 3/9/10

Radiology Reports 11/13/09, 2/20/09, 1/19/10, 12/12/08

Electro-Diagnostic Interpretation 4/7/09

OP Report 5/6/08 and 6/22/09

Dr. 3/19/10 and 1/8/10

Ortho Clinic 7/1/10 thru 8/12/10

Dr. 7/24/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured on xx/xx/xx. He apparently had a shoulder injury requiring surgery and neck and back pain. Most of the records addressed the neck. Dr. noted that he had pain in the low back and down the left leg to the toes. The EMG interpreted by Dr. (4/7/09) was interpreted as showing a left L4 radiculopathy based upon polyphasics in the left lumbar paraspinal muscles, and the left vastus medialis and lateralis. The MRI showed small disc protrusions at L1/2, L2/3 and L4/5. The right greater than the left foramina was narrowed at this level. The L5/S1 was normal. A coincidental Schmorl's nodule was seen at L3/4. He had a small right sided disc protrusion at T3/4 and T8/9. Since most of the examinations addressed the shoulder; Dr.'s exam is the only one of the low back. He stated there was bilateral positive SLR at 45 degrees, absent knee jerks, but did not describe any sensory exam. He did describe prior relief with trigger point injections, and Dr. wanted to perform these again with ESIs.

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

There are several issues here. First, the IRO reviewer is not clear why there is a request for

two ESIs when one of the ODG requirements is that the first provide at least 60% relief for 6 or more weeks. We have no information how the first ESI went before considering a second or third. A series of 3 is not accepted.

The next issue is the presence or not of a radiculopathy. The ODG describes the need for a radicular, dermatomal pain pattern. This may be present. The second is that there be abnormalities on physical examination, especially the neurological exam. These were not described including motor and sensory loss. The absent bilateral knee jerks are less significant than if this was a unilateral finding. The radiological findings document disc problems, but did not show nerve root compression. Dr. made the diagnosis based upon polyphasic potentials. The AMA Guides, which the ODG utilizes, requires spontaneous potentials such as fibrillations or positive waves. Dr. did not find these, so the electrodiagnostic criteria for a radiculopathy was not met.

Lumbar ESIs require the presence of a radiculopathy and that there be an associated active treatment (therapy) program. That was not described. Without confirming the diagnosis of a radiculopathy and an associated treatment program, the ESIs are 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

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)