

Notice of Independent Review Decision

DATE OF REVIEW: 04/01/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar ESI #2

1 Lumbar epidural steroid injection #2 under fluoroscopy between 3/2/11 and 5/1/11

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Based on review of medical documentation, it is recommended that the original denials for lumbar ESI #2 be overturned and that the preauthorization request be approved.

The DYLL REVIEW

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Review of the complete documentation indicates that the original denials were based on the patient's not participating in an appropriate physical therapy or other ongoing treatment program as recommended by the *ODG* for repeat ESI treatment. As this patient was participating in a return-to-work chronic pain management program by documentation, it is reasonable that based on the initial positive response of the first lumbar ESI, a second lumbar ESI would be considered medically reasonable and necessary and in keeping with the *ODG*.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 20 page fax 3/18/11 Texas Department of Insurance IRO request, 92 page fax 3/18/11 URA response to disputed services including administrative and medical records. 49 page fax 3/18/11 Provider response to disputed services including administrative and medical records

- Managed Care Services, 02/28/11 denial for ESI #2.
- 03/04/11, denial for ESI, lumbar #2.
- Medical records from M.D., for dates of 12/07/10, 01/24/11, and 02/14/11.
- Medical documents from Diagnostics 12/07/10 reporting computerized manual muscle testing and range-of-motion testing.
- Various partial references in support of ESI.
- Medical records from M.D., Clinic, beginning 06/16/10 and continuing to 08/04/10, 08/30/10, 09/10/10, and 11/24/10.
- Records from Dr. and Clinic for chronic pain management program 01/20/11, 01/19/11, 01/18/11, 01/14/11, 01/13/11, 01/12/11, 01/11/11, 01/10/11, 01/07/11, 01/06/11, 01/05/11, and 01/04/11.
- Records from date of service 06/15/10.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the available medical information, this patient was originally seen and examined by Dr. on the date of injury, xx/xx/xx. Reportedly, he was employed as a for a period of two months. He was crossing or walking over a pipe rack and fell, striking his back against a pipe. He had non-radiating pain going into the lower back area.

He also was noted subsequently to have come under the care of M.D. The patient was started on a program of physical therapy and also had an MRI performed 06/29/10 at MRI. The MRI of the lumbar spine impression noted bilateral spondylolysis at L5 without appreciable listhesis, diffuse posterior disk bulge, which lateralizes toward the left posterolaterally, which may represent a very small, broad-based 2-mm left foraminal protrusion, moderate left foraminal narrowing, no central stenosis, right neural foramen is patent.

Also on the same date, an MRI of the thoracic spine was done at the same location with the impression of no abnormality and no focal protrusion.

He continued under the care of Dr. and has recently been approved to participate in a chronic pain management program, and there is documentation of participation beginning in January 2011.

The patient was approved for a lumbar ESI to be performed by M.D., which was accomplished 01/24/11. On follow-up 02/14/11, he was noted to have achieved an 80% level of improvement, and Dr. recommended a second ESI to be accompanied with the chronic pain management program. The second ESI was non-approved by Managed Care Services on 02/28/11 and 03/04/11 noting that while the patient had been certified for participation in a chronic pain management program, there was no documentation indicating the patient actually was participating.

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

Based on review of medical documentation, it is recommended that the original denials for lumbar ESI #2 be overturned and that the preauthorization request be approved.

Review of the complete documentation indicates that the original denials were based on the patient's not participating in an appropriate physical therapy or other ongoing treatment program as recommended by the *ODG* for repeat ESI treatment. As this patient was participating in a return-to-work chronic pain management program by documentation, it is reasonable that based on the initial positive response of the first lumbar ESI, a second lumbar ESI would be considered medically reasonable and necessary and in keeping with the *ODG*.

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)