

SENT VIA EMAIL OR FAX ON
Feb/02/2011

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

Amended 2/3/11

Date of Notice of Decision: Feb/02/2011

DATE OF REVIEW:

Feb/02/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L-ESI @L5/S1 with Fluoroscopy Outpatient

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; 11/8/10 and 11/9/10; Lumbar Spine 6/28/10; MRI 4/15/10
11/17/10 and 12/7/10; Dr. 5/6/10 thru 8/1910

PATIENT CLINICAL HISTORY SUMMARY

This xx year old reportedly was injured in a fall on xx/xx/xx. He sustained shoulder pain and low back pain. The MRI in June described posterior disc protrusions at L4/5 and L5/S1. Possibly reaching the left S1 root. He was described as having some occasional right leg pain at times. Dr. noted "The patient is not really complaining of any left sided leg pain at the moment." Dr., Dr. and Mr. described some limited lumbar motion, but all with normal reflexes and sensory examination. The SLR was generally normal. There was a comment by Dr., that when this man was distracted, "there does not appear to be a positive SLR."

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

The ODG accepts a role for lumbar ESI in the presence of a radiculopathy, not low back pain. Abnormal lumbar MRIs are common. The ODG requires evidence of a radiculopathy as described in the AMA Guides, 5th edition. This includes an abnormal EMG, muscle atrophy, asymmetrical muscle weakness and sensory loss or abnormal reflexes. These were not present. The ODG and the AMA Guides require that the pain and paresthesias be in a dermatomal pattern. Occasional right leg or left leg pain does not meet this requirement. This was also not described. SLR is not a criteria. Since a radiculopathy has not been confirmed, the ESIs are not medically necessary at this time.

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)