

SENT VIA EMAIL OR FAX ON
Feb/02/2011

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/02/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One (1) outpatient cadal ESI, as related to the lumbar spine

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

Health Systems-Dr. 5/24/10

Back Institute 7/30/08 thru 11/24/10

MRI 8/13/08

Lumbar Spine 4/23/09

OP Report 11/17/10 and 9/24/08

12/3/10 and 12/20/10

X-Ray 6/18/08

Select PT 11/4/08 thru 11/25/08

PATIENT CLINICAL HISTORY SUMMARY

This is a reportedly injured on xx/xx/xx. He was found to have an L5 radiculopathy based upon physical findings, EMG and the MRI. The latter showed a left paracentral HNP at L5/S1 with a second with bilateral foraminal stenosis at L4/5. He had an ESI reportedly on 11/17/10 and per the follow up report on 11/24/10, a week post procedure, had with left sided LS pain, but greater than 50% relief of the left leg pain. Dr. agreed with the repeating of one ESI in his

IME. A second is requested.

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

The argument is not the justification of an ESI. He had the confirmed diagnosis of a radiculopathy. It is also not the type of injections (eg transforminal vs translaminar vs caudal). The issue is the need for a second injection a week after the first. ESIs are indicated for radiculopathy, and not back pain. He had the relief of the radicular pain, but not the back pain. We are discussing a therapeutic and not diagnostic injection. The ODG specifically cites the repeat ESIs are for the radicular pain, which has improved. The IRO reviewer did not see Dr. explaining how the back pain would benefit with the second injection. Therefore, the request is not medical necessity.

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)