

SENT VIA EMAIL OR FAX ON  
Feb/01/2011

# Applied Resolutions LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jan/31/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar Epidural Steroid Injection L5/S1 with Fluoroscopy #1

**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; Pain Therapeutics 12/28/10; 12/8/10; MRI 11/29/10; Lumbar Spine 10/6/10; 1/4/11 and 1/12/11

**PATIENT CLINICAL HISTORY SUMMARY**

This is a injured xx/xx/xx when his chair leg broke and he fell on his tailbone. His x-rays that day showed significant spondylosis at multiple levels. He had an MRI on 11/29/10 that showed an anterior disc herniation at L2/3, a 2mm diffuse posterior herniation at L3/4, a 7mm central herniation pressing on the thecal sac and entering the lateral recess at L4/5 and a central herniation and right posterolateral herniation to the neural foramen at L5/S1. The history provides bilateral lower extremity pain at night with shooting, sharp and dull pain, worse with bending. He cannot sit, stand or walk more than 15 minutes, but he is at work. His examination showed symmetrical absent knee and ankle jerks, normal sensation and strength, but bilateral positive SLR and an antalgic gait.

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

The x-rays showed the presence of prior degenerative changes in the spine. There is no

description of any dermatomal pain pattern as required by the ODG. Further, the ODG requires that a radiculopathy be based upon neurological findings as described in the AMA Guides, 5th edition. These were not provided. SLR and MRI findings are insufficient to document the presence of a radiculopathy. The ESIs are permitted for the treatment of a radiculopathy and not discogenic pain. There is a role for a diagnostic purpose if the findings are ambiguous and the pain generator is not clear. There were no neurological findings for a radiculopathy. Therefore the criteria per the ODG for the procedure has not been met and the procedure is 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)