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Notice of Independent Review Decision

DATE OF REVIEW: 05-05-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Thoracic Epidural Injection (ESI) at T1-2

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

Certified by The American Board of Anesthesiology
Anesthesiology – General
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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	724.1	62311	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notification of Determination dated, 02-13-08, 03-12-08 and 03-27-08
Appeal requests
Physician's Pre-op Orders / Care report/Follow-up Office Visit

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Notice of Medical Necessity dated, 01-25-08
Physician prescription (referral) dated, 01-18-08 and 12-14-07
Medical notes dated, 01-21-08, 01-14-08, 01-17-08, 09-01-07, 10-08-07,
10-06-07, 10-03-07, 10-09-07, 10-14-06, and 10-24-06
Operative report dated, 10-14-06
Consultation report dated 04-06-08
Medical Evaluation Report dated, 11-26-07
Official Disability Guidelines (ODG): Criteria for the use of Epidural Steroid
Injection

PATIENT CLINICAL HISTORY:

The provided medical documentation indicated that the patient was originally injured on xx/xx/xx when he fell at work and suffered multiple rib fractures. The office visit of February 5, 2008 noted the patient is complaining of mid back pain and cervical pain with radiation into the left upper extremity with decreased sensation (it was not specified if this was to light touch or pinprick) in the left C7 to T1 dermatomes. There is no supporting radiographic examination of the cervical spine, but a prior thoracic spine MRI revealed no spinal stenosis with minimal disc bulging at the T7-8 level. The treating provider's request for ESI was non-certified.

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

Per review of the ODG guidelines, "epidural steroid injections are recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distributions with corroborative findings of radiculopathy) with use in conjunction with active rehabilitation efforts. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESI's have not been found to be as beneficial a treatment for the later condition". The criteria for ESI includes but is not limited to:

- 1) A radiculopathy that must be documented. Objective findings on examination need to be present, and these must be corroborated by imaging studies and/or electrodiagnostic testing
- 2) Initially unresponsive to conservative treatment
- 3) Injections should be performed with fluoroscopy

In the opinion of the Physician Reviewer, the medical records do not support the indicated procedure as there is no evidence of nerve root compression and radicular symptoms. There is a lack of radiographic, electrodiagnostic and

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physical examination findings that would necessitate a thoracic epidural steroid injection.

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)