

# US Decisions Inc.

An Independent Review Organization  
71 Court Street  
Belfast, ME 04915  
Phone: (512) 782-4560  
Fax: (207) 470-1085  
Email: manager@us-decisions.com

**DATE OF REVIEW:**

Mar/23/2009

**IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Upper GI Endoscopy, 43235

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

MD, Board-certified Internal Medicine.

**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**

Adverse Determination Letters, 2/17/09, 2/26/09

MD, 2/12/09

MD, Letter of Medical Necessity, 3/17/09

MD, Exam Notes, 3/9/09, 3/12/09, 12/22/08

Medication Log, 9/2/08-3/5/09

MD, Letter of Medical Necessity, 3/17/09

ODG Guidelines and Treatment Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This female sustained a fall injury on xx/xx/xx with neck, back, and abdominal injuries. Proton pump inhibitor therapy was initiated in December 2007 without significant improvement of symptoms. CT of the chest showed a hiatal hernia. The claimant has been recommended by the consulting gastroenterologist for EGD.

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

The reviewer has reviewed the applicable guidelines and the peer-reviewed medical literature concerning the use of EGD in the evaluation of abdominal pain. EGD is indicated for diagnostic evaluation for signs or symptoms suggestive of upper GI disease that has not responded to standard therapy, surveillance for upper GI cancer in high-risk settings, for biopsy for known or suggested upper GI disease, or for therapeutic intervention. The claimant has a twelve-month history of upper abdominal pain, unchanged with two months of

a proton pump inhibitor. She fulfills the indication for EGD as outlined above. The guidelines have been met. The reviewer finds that it is within a degree of medical probability that the claimant would derive substantial clinical benefit from the proposed procedure. The reviewer finds that medical necessity exists for ODG Guidelines and Treatment Guidelines.

**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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

Sleisenger & Fordtran's Gastrointestinal and Liver Disease, 8th ed.  
Textbook of Gastroenterology, vols 1 & 2, 4th ed.

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)