

I-Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Op Bilateral T8-9 Transforaminal Epidural Steroid Injection w/Fluoro 64479 x 2, 77003, 99144

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/27/09, 12/2/09
MRI Thoracic Spine with and without contrast, 4/27/09
MD, 11/20/09, 10/19/09, 9/21/09
MRI of the Lumbar Spine with and without contrast, 4/27/09
Examination Two-View Chest, 4/10/09
Examination Lumbar Spine, 4/10/09
Initial Medical Progress Notes, 4/13/09
Medical Progress Note, 4/27/09, 5/4/09, 5/18/09, 6/15/09, 6/27/09, 6/29/09, 8/14/09
FCE, 6/30/09
MD, 7/7/09, 10/6/09
PT Progress Notes, 4/15/09-5/13/09
ODG, Criteria for the use of Epidural Steroid Injections

PATIENT CLINICAL HISTORY SUMMARY

This is a woman with an injury date of xx/xx/xx. The records describe complaints of mid back and low back pain with occasional radiation to the lower extremities. The MRI of the thoracic and lumbar spine showed spondylotic changes at multiple levels with small disc herniations from T6-9, stenosis at T10/T11, right foraminal stenosis at T8/9 and left at T5/6. There is severe left L5/S1 foraminal narrowing with mild stenosis through the lumbar spine. The physical findings describe local spinal tenderness and positive SLR. There were no neurological findings reported. Dr. felt that there is no weakness, but radicular pattern.

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

This patient has back pain. In order to recommend ESI, the ODG requires demonstration of pain in a radicular/dermatomal pattern. This was not described in any of the examination records made available for this review. A letter from Dr. [redacted] written after the procedure was denied stated there was a radicular pattern. In his letter, he also states that it is difficult to demonstrate motor weakness with thoracic radiculopathies. The examination records, however, did not contain any physical description of any sensory findings, normal or abnormal, in any of the dermatomes in the thoracic or lumbar region, nor any description of any reflex findings. Dr. [redacted] felt the MRI findings are sufficient to justify the procedure. However, without the physical findings confirming a radiculopathy, the procedure does not meet the criteria as determined by the ODG. The reviewer finds that medical necessity does not exist for Op Bilateral T8-9 Transforaminal Epidural Steroid Injection w/Fluoro 64479 x 2, 77003, 99144.

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)