

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/02/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

B/L Epidural Steroid Injection @ L4-5 Outpt 62311

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

M.D., Board Certified in Anesthesiology and Pain Management, American Board of Anesthesiologists

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

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 3/18/10, 4/7/10
MD, 2/24/10, 3/4/10, 3/11/10
Lubbock, 2/17/10
Medical Group, 2/5/10
PT Note, 3/23/10
Lumbar Spine Series, 2/5/10

PATIENT CLINICAL HISTORY SUMMARY

Records indicate this patient has a history of thoracic and lumbar spine pain that does not radiate. Physical exam is significant for a positive straight leg raise on the left for "back pain and radiculopathy" and on the right for "back pain." A lumbar spine MRI from 2/17/10 is significant for a 2mm broad-based disc bulge at L4-5. Per the CPT code submitted (62311), the request is for an interlaminar ESI at L4-5 bilaterally.

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

Per the ODG, radiculopathy must be documented. According to the office visit notes, the patient has no radicular symptoms. The physical exam mentions that there is a positive straight leg raise on the left for "radiculopathy." Radiculopathy is a diagnosis and not a physical exam finding. The patient has no complaints of radicular symptoms. The request does not conform to the ODG criteria for ESI. The reviewer finds that medical necessity does not exist for B/L Epidural Steroid Injection @ L4-5 Outpt 62311.

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)