

US Decisions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Transforaminal Lumbar ESI Left L5 and S1 under Fluoroscopy Epidurography

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

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

Letters, 7/13/10, 7/27/10

Preauthorization Request, 7/7/10

Center, 7/7/10, 7/21/10

DO, Office Notes, 7/7/10, 5/18/10

Lumbar Spine MRI with and without contrast, 6/8/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female injured on xx/xx/xx. Per the office visit note on 7/7/10, the patient complains of pain that "radiates from the low back to the buttocks, left hip, left ankle, and top of the left foot." There is no thigh or lower leg pain noted. There is a general statement noted that states that the patient has "a lot of pain to the... left leg." There is no specific dermatomal pattern described. Physical exam is significant for a positive straight leg raise on the left, decreased sensory response in the left L5 and S1 distribution, and 4/5 muscle strength with dorsiflexion of the left ankle extensor hallucis. A MRI, performed on 6/8/10, did not show any significant canal stenosis at L5-S1. The patient underwent a spinal cord stimulator trial but does not want to proceed with a SCS implant. There is no mention of the patient having undergone physical therapy. Per the 7/7/10 note, the "procedure is being contemplated in order to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and thus hopefully avoiding surgery." There is also a note from 7/21/10 that changes the rationale for performing the ESI. Originally, the intent was for therapeutic reasons (7/7/10 note). According to the 7/21/10 note, the purpose for the ESI is for diagnostic reasons. There is no mention as to what the plan would be if these levels were found to be the cause of the patient's pain.

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

According to the Official Disability Guidelines, an ESI is indicated if the patient is "initially unresponsive to conservative treatment." There was no documentation of the patient being involved in PT. Also, the patient's radicular symptoms are poorly described. With the current description, it is unclear what dermatomal pattern, if any, is present. Therefore, the history

cannot be correlated with the physical exam. In addition, the MRI does not show any pathology at the level in which the ESI is being requested. For these reasons, a diagnostic ESI does not satisfy the ODG criteria. According to the 7/21/10 note, the purpose for the ESI is for diagnostic reasons. There is no mention as to what the plan would be if these levels were found to be the cause of the patient's pain. If the ESI is for diagnostic reasons, a plan should be formulated in case these levels are shown to be the cause of the patient's pain. According to ODG, diagnostic tests should not be ordered/performed unless it is going to change the plan of treatment. Therefore, the reviewer finds that medical necessity does not exist at this time for Transforaminal Lumbar ESI Left L5 and S1 under Fluoroscopy Epidurography.

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)