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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/19/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left T9/10 and T10/11 Costovertebral Injection, CPT codes 64450 and 77003-26

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

M.D., Board Certified Orthopedic Surgeon

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

Official Disability Guidelines

Peer Review 05/31/11, 06/02/11, 06/16/11

Dr. OV 10/27/09, 12/04/09, 12/23/09, 01/14/10, 06/16/10, 06/18/10, 07/02/10, 07/30/10, 10/12/10

Dr. OV 01/27/11, 03/14/11, 05/24/11

X-ray thoracolumbar spine 10/12/10

MRI lumbar spine 09/08/09

MRI thoracic spine 01/24/11

Procedure 10/19/09, 02/16/11, 05/24/11

PATIENT CLINICAL HISTORY SUMMARY

This is a male claimant who reportedly injured his back in xx/xx when he was hit and dragged by a tree. Initial diagnosis was lumbar strain along with ruptured spleen. The claimant was noted to have intermittent mid and lower back pain and ongoing left sided pain in the lower thoracic area and left upper quadrant area since the injury. A lumbar MRI dated 09/08/09 was within normal limits. Conservative measures for the lumbar spine included medications, physical therapy and facet joint injections which provided significant relief.

Physician records of 2011 revealed the claimant with persistent mid and lower back pain along with extremity pain and with some left anterior lower rib pain. A thoracic MRI dated 01/24/11 showed minimal multilevel posterior disk bulges without focal protrusion, central spinal stenosis or foraminal stenosis. A left T10 – T11 intercostal nerve block was performed on 02/16/11 with the claimant reporting greater than 50% relief when static and greater than 25-30 % relief when doing actual activities. A second block was preformed on 03/30/11.

A 05/24/11 physician record noted the claimant with ongoing pain however the upper

quadrant abdominal area in the side area in the lateral costal region had been significantly improved with the two intercostal blocks. According to the treating physician, the claimant was having some problems with lower left side rib pain, which might benefit from a general surgeon's evaluation due to the claimant's history of splenic rupture. One last injection was recommended for diagnostic purposes and therapeutic relief.

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

This is a gentleman who sustained a work-related injury in xx/xx. There are recent medical records documenting back pain and left upper quadrant pain. The claimant has had two previous T10-11 intercostal nerve blocks, which gave some short-term improvement in his complaints. He has undergone a 01/24/11 MRI of the thoracic spine whose report does not describe any posterior rib or rib/spine junction abnormality.

The most recent medical record, 05/24/11, Dr., does not describe any local tenderness or radicular sensation issues. There has not been a bone scan documenting abnormal uptake or arthritis in the area of the requested injection.

Official Disability Guidelines do not address this issue. In light of the fact that there are no documented positive physical findings such as specific tenderness, and no documentation of abnormality on the MRI test, then the requested injection is not medically necessary. The reviewer finds no medical necessity for Left T9/10 and T10/11 Costovertebral Injection, CPT codes 64450 and 77003-26.

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)