

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: March 4, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5 ESI Bilateral C5-6 Facet Injection

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

1/10/11, 1/29/11

Orthopaedic Group, LLC 9/23/10 to 1/19/11

8/6/10 to 8/17/10

Chiropractic Neurology & Rehab Group 8/2/10 to 2/9/11

Imaging 7/27/10

Institute of Texas, P.A. 8/30/10 to 12/8/10

Official Disability Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a woman injured x/xx/xx with a fall. She reportedly had a menisectomy. She has ongoing back pain going to the right buttock. She has localized neck pain with a positive Spurling sign. She has local tenderness over the C5/6 facets. Dr. noted that she has a right side SLR at 60 degrees giving buttock but not lower extremity pain. There are numerous reports of normal reflexes and sensation. There is no atrophy. Her EMG showed CTS but no evidence of a cervical or lumbar radiculopathy. Her cervical MRI showed disc herniations at C4/5, C5/6 and C6/7. The lumbar MRI showed multiple disc bulges in the lumbar spine fro L2 to S1. The left and right L4 and L5 roots may be compromised.

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

The first issue is whether she meets the requirements for a lumbar ESI. This requires the presence of a radicular pain pattern and not limited to radiological findings. As written in the AMA Guides, "The presence of findings on a imaging study in and of itself does not make the diagnosis of radiculopathy." This requires neurological abnormalities to include at least abnormal root sensory findings, or abnormal reflexes, or abnormal motor function, or abnormal EMG. Dermatomal and nondermatomal complaints are not sufficient. The provider is in error when he states that the symptoms alone without a neurological deficit suffice.

Further, the patient's complaints were limited to the buttock pain and not in a dermatomal pattern. Therefore, the L5 ESI is not found to be medically necessary per the ODG requirements. The ODG addresses facet joint pain and injections. The description to meet the requirements for facet pain include local tenderness, axial pain, limited motion and no radicular or neurological loss. These requirements are not met. The diagnostic studies are justified prior to a rhizotomy. That is not being considered here. The provider has stated that the intent is to confirm the diagnosis of the facet joints as the pain generator. Since the ODG will only justify the procedure if the rhizotomy will be considered, and it will not in this patient, the request for Bilateral C5-6 Facet Injection does not meet ODG criteria. Therefore, the Bilateral C5-6 Facet Injection is not found to be medically necessary per the ODG requirements. The reviewer finds that there is no medical necessity at this time for L5 ESI Bilateral C5-6 Facet Injection.

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 KNOWLEDGBASE

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)