

# I-Decisions Inc.

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW:** September 29, 2007

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Third right L4, L5 transforaminal epidural steroid injections with fluoroscopy (64483, 77003, 99144)

### **A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

M.D., Board Certified in pain management and anesthesiology under the 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)

Agreement with the denial of a third right L4-5 transforaminal epidural steroid injection.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Denial Letters 8/20/07 and 7/25/07

ODG Guidelines

Appeal Letter, Dr., 8/10/2007

Evaluations from 2007: 5/1,5/8,5/29,6/21,7/3,7/19,9/6

Initial Narrative Report, 4/23/07

EMG and NCV Study, 4/18/07

Letter of Medical Necessity 4/10/07

Procedure Report 5/21/07

Initial Report 4/25/07

Mid-Term Update 6/13/07

Discharge Update 7/3/07

Daily Progress Notes for Pain Progress, Massage, Acupuncture, Group Therapy, Individual Therapy, Bio-Feedback and Nutrition.

Dr. Report 7/5/07

Medical Necessity letters from 4/18/07, 7/24/7 and 8/17/07

Summary

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was injured on the job on xx/xx/xx. His injury caused him to have low back pain. He has completed physical therapy and a chronic pain program and received two right L4-L5 transforaminal epidural steroid injections. It is noted that the first epidural steroid injection provided the patient with 50-60% pain relief for approximately two weeks. It was noted at an office visit with Dr. on 05/29/2007 that the second injection did not provide any pain relief. This was eight days after the second right L4-L5 transforaminal epidural steroid injection was performed. There is no mention in any of the office visit notes regarding whether or not the patient's function improved from the epidural steroid injections.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

From the physical exam results that I have been able to review from clinic notes, there have been no objective findings on exam for radiculopathy. In addition, an EMG/NCV study that was performed on 04/18/2007 did not suggest any signs of radiculopathy or neuropathy. Therefore, epidural steroid injections were probably not appropriate even at the beginning of the patient's treatment. A third transforaminal epidural steroid injection is definitely not appropriate at this time. According to the letter submitted by Dr., the patient received more than 70% pain relief with his symptoms. This was not documented in the office visit notes. Even if the patient did receive 70% pain relief, it only lasted approximately two weeks. A repeat steroid injection is not indicated unless there is documentation of at least 50-70% pain relief for at least 6-8 weeks after the epidural steroid injection has been performed (taken from Official Disability Guidelines). Therefore, I am not recommending a third right L4, L5 transforaminal epidural steroid injection.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN 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)