

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 4, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal epidural steroid injection (ESI) x 1 @ L4, L5, and S1 with fluoroscopy.

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

Board-certified Internal Medicine, Specialized in Occupational Medicine.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notification of Case Assignment, Medical Records from Requestor, Respondent, Treating Doctor(s), including:

URA Denial Letters, 7/2/07; 7/31/07

Dr. letters, 6/25/07, 7/10/07

Dr. July 2006 to May 2007
Clinic Notes, 7/11/06; 8/1/06; 11/9/06; 12/7/06; 1/16/07; 1/30/07;2/20/07; 5/3/07
Dr. May 2007
Dr. letter to Dr. 4/16/07
Hospital, Radiology Reports, 5/3/07, 6/5/07, 1/26/07, 7/21/06, 9/12/06
Imaging Radiology Report, 3/3/06
Dr. letter to Dr. 9/15/06
Hospital, History and Physical, 10/30/06
Hospital, Operative Report, Blum, 4/28/06
Dr. Operative Note, 10/30/06
Physical Therapy Notes, 11/22/06
MD, Pain Therapeutics, 7/24/06, History and Physical
Therapeutics Office Visit Notes, 5/3/07
Dr. Operative Report, 4/28/06
Dr. Letter to to Dr. 6/20/06
Dr. Initial Evaluation, 4/10/06
Dr. Letter to Dr. 5/3/07
Dr. Letter to Dr. 3/23/07
1/8/07, 12/13/06
Healthcare, 11/22/06
ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant injured his lower back when he lifted. He underwent L5-S1 laminectomy in April 2006 and fusion in October 2006. Physical examination demonstrates radicular pain. CT myelogram (post-operative) shows right L5-S1 foraminal stenosis, but the claimant's symptoms are on the left side. He has been recommended for ESI for pain control. Further surgery is not mentioned in the records.

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

I have reviewed the applicable guidelines and the peer-reviewed medical literature concerning ESIs in the management of pain in the post-operative lumbar spine. ESIs are recommended when radicular signs are present as an adjunct in the pre-operative period. By itself, this procedure offers no significant benefit over the long term. Since this claimant is not a surgical candidate, it is beyond a degree of medical probability that he will derive substantial benefit from the proposed procedure.

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)