

US Decisions, Inc.

An Independent Review Organization

71 Court Street (512)

782-4560 (phone) (207)

470-1085 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: 04/12/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar ESI with fluoroscopy (62311)

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

Board Certified Neurosurgeon with additional training in Pediatric Neurosurgery

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)

Upon independent review the reviewer finds that the requested outpatient lumbar ESI with fluoroscopy is medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient has a date of injury xx/xx/xxxx. He is status post L3-L4 fusion in 09/18/1998. He complains of low back pain radiating to bilateral legs with numbness and weakness. An exam from 11/14/2005 shows some weakness of the left quadriceps and an absent left knee jerk. He had known problems at L2-L3, and has never been operated on at this level. A recent myelogram showed significant bilateral neuroforaminal stenosis at L2-L3. There is mild neuroforaminal narrowing at L1-L2 and L4-L5. There is no central canal stenosis.

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

The procedure is medically necessary. The patient does have evidence of a left L3

radiculopathy as exhibited by a decreased knee jerk and quadriceps weakness on the left. There is pathology (severe neuroforaminal narrowing) at L2-L3 to account for this. Although a recent neurological examination has not been performed, the provider indicates that the exam has been the same and is now worsening. There is no reason to believe that his radiculopathy no longer exists, since he has been living with this radiculopathy for some time and has never been treated at this level with surgery. Therefore, an epidural steroid injection is medically necessary.

References/Guidelines

ODG "Low Back" chapter

Criteria for the use of Epidural steroid injections:

1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.

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)