

I-Decisions, Inc.

An Independent Review Organization

71 Court Street

Belfast, ME 04915

Fax: 866-676-7547

Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 26, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Translaminar Lumbar ESI #2, L4-5 under fluoroscopy with x-ray

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)

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.

The reviewer finds that medical necessity does not exist for Outpatient Translaminar Lumbar ESI #2, L4-5 under fluoroscopy with x-ray.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/8/08, 7/16/08, 8/11/08
ODG Guidelines and Treatment Guidelines

, undated letter
Referral Form, 7/15/08
Operative Report, 6/12/08
, MD, 4/17/08, 3/28/08, 3/26/08, 3/6/08, 3/5/08, 3/3/08, 2/25/08
MRI of Lumbar Spine without contrast, 2/5/08
Cervical Spine, 5 Views, 1/4/08
Letter to IRO, 8/13/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured while on the job after being involved in a motor vehicle accident on xx/xx/xx. Since that time the patient complains of low back pain. The patient underwent a “translaminar epidural” at L4-5. A follow-up visit states that the patient’s pain was “slightly improved.” There is no mention as to how much the patient’s pain was relieved and for how long. There is also no mention of any increase in function.

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

Per the Official Disability Guidelines, when an epidural injection is being performed in a diagnostic phase, a repeat block is not indicated if “there is inadequate response to the first block.” The Official Disability Guidelines define an inadequate response as “less than 30% pain relief.” As stated above, there is no mention as to how much pain relief the patient received from the initial epidural steroid injection. In addition, it is stated that the patient’s pain was “slightly improved.” There was no mention of an increase in function. It does not sound from the records reviewed as though significant pain relief was achieved. Therefore, at this time, a repeat epidural steroid injection is not indicated. The reviewer finds that medical necessity does not exist for Outpatient Translaminar Lumbar ESI #2, L4-5 under fluoroscopy with x-ray.

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)**