

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 4, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right L5-S1 lumbar facet injection with fluoroscopy, right posterior at ligamento-osseous injection and right sacroiliac joint injection x 3.

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 there is not medical necessity for right L5-S1 lumbar facet injection with fluoroscopy, right posterior at ligamento-osseous injection and right sacroiliac joint injection x 3.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 12/14/07, 12/24/07

ODG Guidelines and Treatment Guidelines

Pain Institute, MD, 1/16/06, 4/17/06, 9/19/06, 11/14/06, 1/9/07, 4/16/07, 12/3/07, 1/7/08

Operative Reports, 5/8/06, 6/26/06, 1/30/07, 2/13/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient has a history of chronic right low back pain. She has done well in the past from a right L5-S1 lumbar facet injection, right SI joint injection, and ligamento-osseous steroid injection performed at on the same day. From the notes that I have received, it appears that she has received five months, nine months, and most recently eight months of relief from these injections. It is noted that on the office visit dated 12/03/07 the patient's pain had returned.

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

While this injection has been performed in the past and has provided this patient with pain relief, the reviewer does not agree with the request for a series of three of these injections. The claimant does not meet the ODG guidelines, and therefore the reviewer finds that the request for right L5-S1 lumbar facet injection with fluoroscopy, right posterior at ligamento-osseous injection and right sacroiliac joint injection x 3 is not medically necessary.

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)