

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 13, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral L5 transforaminal epidural steroid injection.

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

M.D., Board Certified in Anesthesiology with Certificate of Added Qualifications by the American Board of Anesthesiology in Pain Management, in practice of Pain Management for 22 years

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 12/27/07, 1/16/08, 1/30/08

ODG Guidelines and Treatment Guidelines

MD, 1/18/08

Clinic, 12/26/07

CT Lumbar Spine w/o contrast, 12/17/07

MD, 12/17/07

MD, 12/26/07, 12/21/07, 1/10/08, 12/17/07, 11/20/07, 1/21/08, 11/21/07, 11/5/07,

11/2/07, 10/23/07, 10/24/07, 10/15/07, 10/8/07, 7/20/07, 7/9/07, 7/6/07, 6/22/07

MRI of the Lumbar Spine w/o contrast, 5/24/07

Undated letters to patient x2

MD, 9/10/07, 9/7/07, 9/5/07, 9/6/07, 8/31/07, 8/28/07, 8/27/07, 8/16/07, 8/14/07, 8/13/07,
8/10/07, 8/8/07, 8/1/07, 7/27/07
MD, 7/10/07
MD, 7/3/07
Patient Questionnaires, 6/22/07, 10/23/07, 11/20/07, 12/21/07
PT, 8/2/07
Rehabilitation Program Progress Notes, 8/27/07-9/7/07 and 8/13/07-8/24/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This individual has low back pain after an injury that occurred on the job on xx/xx/xx. Physical therapy and "Accu-Spine decompression" along with medications have been provided. An epidural steroid injection performed in July 2007 provided 20% pain relief. This individual has back pain only with no leg pain. An MRI scan was reported to show a herniated disc at L4/L5.

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

The reviewer finds that that the previous adverse determinations should be upheld.

The ODG Guidelines state that there should be clear evidence of radiculopathy. This criteria is not met. There is no radiculopathy present in this individual. Therefore, it is neither reasonable nor necessary to perform a bilateral 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)**