

US Decisions, Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 28, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral Lumbar ESI w/Anesthesia and Fluoroscopy L2-L3

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

MD, Board Certified in Anesthesiology and Pain Management

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 Bilateral Lumbar ESI w/Anesthesia and Fluoroscopy L2-L3.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/18/08, 9/5/08

ODG Guidelines and Treatment Guidelines

, MD, 10/4/07, 8/6/07, 7/16/07, 6/28/07, 2/12/07, 1/29/07, 1/4/07, 12/11/06

, MD, 10/16/06, 4/16/07, 6/27/08, 4/28/08

MRI of Lumbar Spine with and without contrast, 9/20/06

Post Op Status Sheet, 1/1/07, 7/16/07

Prescription, 8/6/05

Lumbar Myelogram, 4/23/08

Post Myelogram Lumbar CT, 4/23/08

Peer Review Letter, 6/5/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured on the job on xx/xx/xx. The patient has undergone an L3-S1 fusion. The patient has also received a bilateral L2, L3 transforaminal epidural steroid injection in the past. One injection provided the patient with 50% pain relief for two weeks and the other provided 40% pain relief for an undisclosed amount of time.

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

Per the Official Disability Guidelines, a therapeutic epidural steroid injection can only be performed if the diagnostic epidural steroid injection provided the patient with 50-70% pain relief for 6-8 weeks. This type of pain relief has not been documented, and therefore, it would not be considered appropriate to repeat this epidural. The reviewer finds that medical necessity does not exist for Bilateral Lumbar ESI w/Anesthesia and Fluoroscopy L2-L3.

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)