

I-Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/05/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar ESI

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

M.D., Board Certified Orthopedic Surgeon

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 Notices, 5/20/09, 5/28/09, 6/8/09

ODG Guidelines and Treatment Guidelines

Rehab Therapy Resources -- Ph. D: Initial eval 04/21/03, follow ups -- 08/01/03; 11/04/03; 04/02/04; 09/22/04; 02/22/05; 10/18/05

Dr. Office Records: 03/31/09; 05/02/09

Authorization Request for lumbar ESIs: 05/13/09

Dr. --- Letter of Medical Necessity: 05/22/09

Letter of Withdraw of request -- lumbar ESIs: 06/08/09

Request for Independent Review for Lumbar ESIs: 06/20/09

PATIENT CLINICAL HISTORY SUMMARY

This male sustained a trip and fall injury on xx/xx/xx striking his low back and landing in a twisted position. Documentation revealed a prior history of an L4-5 hemilaminotomy and micro-discectomy with foraminotomy and L5-S1 hemilaminotomy done 12/30/99 with the development of a severe staph infection postop requiring a 4 week inpatient stay due to severe pain and debilitation with successful completion of psychotherapy and return to full duty prior to his current injury. The 04/21/03 evaluation completed by Ph. D revealed a diagnosis of mood disorder, major depression, sleep disturbance and stress- related

symptoms. The claimant underwent extensive individual and group psychotherapy sessions with documented excellent therapeutic response to supportive training in rehab coping skills. The claimant was evaluated by Dr. on 03/31/09 for acute severe right sided L5 radiculopathy and pain in the L4 and L5 distribution. Documentation revealed a diagnosis of chronic pain syndrome, failed back syndrome, acute right L5 severe motor radiculopathy, lumbago, spinal stenosis and neuroforaminal stenosis.

The claimant underwent a right sided L5 transforaminal epidural steroid injection on 03/31/09 with reported 60 to 80 percent pain relief noted in a letter of medical necessity dated 05/22/09. The 05/02/09 office records revealed the claimant had also been able to decrease his consumption and requirement of pain medications following the first lumbar epidural steroid injection. Dr. requested authorization to proceed with a 2nd lumbar epidural steroid injection.

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

The evidence based guideline suggests that epidural steroid injections can be recommended for individuals who have documented signs of radiculopathy and for whom initial conservative care has failed. In general the guidelines state that a series of epidural steroid injections is not recommended, and that one is most appropriate unless there is a substantial improvement with that injection.

The request for a second epidural steroid injection in this particular case would appear to be reasonable and appropriate. According to these subsequent reports this gentleman got 60 to 80% relief following his original injection. One could reasonably conclude that a second injection might offer him improved benefit based on the initial response to the first injection.

The request meets the guidelines. The reviewer finds that medical necessity exists for Lumbar ESI.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates: Low Back -- Epidural steroid injections (ESIs), therapeutic

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)