PRIME 400 LLC

240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 1, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of ESI lumbar injection L4-5; ESI cervical injection C5-6

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

MD, 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)

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 ESI lumbar injection L4-5; ESI cervical injection C5-6

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office note, Dr. , 01/11/08
MRI Cervical Spine, 02/05/08
Operative report, Dr. , 06/17/08
Office note, Dr. , 09/26/08
Pre-certification request, 10/07/08, 10/14/08
Reconsideration request, 10/08/08, 10/31/08, 11/11/08
Notification of Determination, 10/14/08
Prescription, 10/21/08

Office note, Dr. , 10/22/08
Referral form, 11/05/08
Peer review, Dr. , 11/07/08
Peer review, Dr. , 10/02/08
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year old female was injured on xx/xx/xx while unloading a truck. She reportedly felt immediate low back pain and had trouble standing upright. Documentation revealed the claimant was examined by the company physician, x-rayed and ordered physical therapy and medications. The claimant was diagnosed with cervical and thoracic strain/sprain as well as lumbar disc disorder and sacroiliac joint dysfunction bilaterally.

On 02/05/08, the claimant underwent a thoracic MRI which revealed evidence of moderate S-Shaped scoliosis of the thoracic spine and a cervical MRI which revealed reversal of the mid-cervical lordosis with muscle spasm or strain and disc protrusions at C3-4 through C6-7 which press on the anterior thecal sac without neural foraminal narrowing.

Documentation from Dr. dated 09/26/08 revealed the claimant had undergone lumbar epidural steroid injections on 04/08/08 and 06/17/08 with improvement in her pain but the pain returned and he noted the claimant had not sufficiently improved with conservative treatment. Exam findings revealed normal motor strength, sensation and reflexes in her bilateral upper and lower extremities with moderate restrictions in range of motion of the cervical and lumbar spine. She had paravertebral muscle spasms in the cervical and lumbar spine but had tenderness to palpation in the cervical spine only. Straight leg raises were negative bilaterally.

A diagnosis of discogenic cervical and lumbar pain with bilateral lumbar radiculitis and multilevel cervical and lumbar disc protrusions was noted and the surgeon requested authorization for a C5-6 and L4-5 epidural steroid injections.

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

On our review there are no clear cut radicular findings or deficits in these medical records. In the absence of evidence of radiculopathy and in accordance with ODG Guidelines the reviewer cannot recommend as medically necessary epidural steroid injections. The reviewer finds that medical necessity does not exist for ESI lumbar injection L4-5; ESI cervical injection C5-6.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates
** Recommended as a possible option for short-term treatment of radicular pain with use in conjunction with active rehab efforts

1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy
2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

3) Injections should be performed using fluoroscopy and injection of contrast for guidance.
4) *Diagnostic Phase:* At the time of initial use of an ESI a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
5) No more than two nerve root levels should be injected using transforaminal blocks.
6) No more than one interlaminar level should be injected at one session.
7) *Therapeutic phase:* If after the initial block/blocks are given and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be required. Indications for repeat blocks include acute exacerbation of pain, or new onset of symptoms. The general consensus recommendation is for no more than 4 blocks per region per year.
8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks as this may lead to improper diagnosis or unnecessary treatment.

Cervical and lumbar epidural steroid injection should not be performed on the same day.

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)**