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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/04/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar ESI #2 at L3/4; Fluoroscopic Guidance Lumbar; Conscious Sedation; Lumbar ESI Additional Level

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

Peer reviews, 1/26/09, 2/19/09

ODG Guidelines and Treatment Guidelines

Dr. office notes 04/05/06, 04/19/06, 05/17/06, 06/07/06, 08/16/06, 08/23/06, 01/24/07, 07/11/07.

MRI lumbar spine 4/18/06

Associate statement 04/09/08

Work comp medical care request 04/09/08

Supplemental report of injury 04/09/08

Work status report 04/09/08, 04/11/08, 04/17/08, 05/14/08, 05/21/08, 08/18/08, 09/30/08, 11/12/08, 11/24/08

Injury/trauma report

Office notes 04/09/08, 04/11/08, 05/01/08, 05/14/08, 05/21/08, 11/24/08

X-ray right shoulder 04/09/08

Employer's first report of injury

Dr. office notes 05/12/08, 06/25/08, 09/03/08, 10/08/08, 11/12/08, 02/04/09

MRI lumbar spine 06/20/08

MRI right shoulder 05/23/08

Physical therapy notes 05/28/08 to 08/11/08

Claims management correspondence 05/05/08

Dr. office note 07/16/08

Dr. letter 08/19/08, 02/13/09
Independent review determination 10/23/08
Medical prescription 10/24/08
Dr. letter 11/06/08, 02/02/09
Texas Dept of Insurance hearing decision
01/08/09 Peer review
01/12/09 Procedure report

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who injured his low back and right shoulder on xx/xx/xx. Evaluation on 05/12/08 by Dr. documented exam findings of slightly antalgic gait and pain with heel walking. The claimant had restricted and painful lumbar range of motion. Straight leg raise was 30 degrees on the right with back and right buttock pain and 50 degrees on the left limited by back pain. Motor/sensory exam was normal. Reflexes were one plus. A 06/20/08 MRI of the lumbar spine showed posterior central, paracentral disc protrusion at L3-4 with thecal sac impingement with suggestion of subligamentous mild migration inferiorly and centrally and associated right neural canal narrowing. There was a posterior central, paracentral disc protrusion at L4-5 with thecal sac impingement and a posterior disc bulge extending laterally asymmetric on the left at L2-3.

On 6/25/08 Dr. saw the claimant in followup for low back and right leg pain. The diagnosis was L3-4 and L4-5 disc herniations and right sided sciatica. The claimant was referred for plasma disc decompression at L3-4 and L4-5 that was denied by the insurance carrier. Dr. then recommended epidural steroid injections. On 01/12/09 a right L3 and L4 transforaminal epidural steroid injection was given. On 02/04/09 Dr. noted that the claimant had complete relief of pain for about a week but the pain had returned. A second epidural steroid injection was requested but denied on peer review.

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

The requested second lumbar epidural steroid injection at L3-4 with a lumbar epidural steroid injection at an additional level is not medically necessary based on review of the medical records. While this claimant has back pain and Dr. has documented his ongoing subjective complaints, he has not documented any evidence of neurologic deficit, protective muscle spasm, disuse muscle atrophy, or other objective abnormality. This claimant did have short-term decreased pain complaints following his first epidural steroid injection, but Dr. does not document how that corresponded with any change in his underlying condition. ODG guidelines describe the use of epidural steroid injections in patients who have a documented radiculopathy with objective findings on examination, which does not appear to be present in this case. ODG guidelines also discuss repeat injections based on decreased need for pain medication and functional response, as well as the fact that current research does not support a routine use of a "series of three" injections. Dr. has requested another injection, however, he has not documented radicular anatomic findings, has not documented decreased use of pain medication and objective functional improvement following the first injection. The request does not meet the ODG guidelines. The reviewer finds that medical necessity does not exist for Lumbar ESI #2 at L3/4; Fluoroscopic Guidance Lumbar; Conscious Sedation; Lumbar ESI Additional Level.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates. Low back

Criteria for the use of Epidural steroid injections

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit

(1) Radiculopathy must be documented. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-

383. (Andersson, 2000)

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)

(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance

(4) Diagnostic Phase: At the time of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will be obtained with this treatment intervention), 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 (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be required. This is generally referred to as the “therapeutic phase.” 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. (CMS, 2004) (Boswell, 2007)

(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 or trigger point injections as this may lead to improper diagnosis or unnecessary treatment

(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)