

PRIME 400 LLC
240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 16, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injection with fluoroscopy

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 Lumbar epidural steroid injection with fluoroscopy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Dr. Office Records: 03/05/07; 05/17/07; 07/10/07; 08/23/07; 09/20/07; 11/15/07;
12/13/07; 01/03/08; 06/24/08; 11/18/08
Adverse Determination Letters, 12/03/08 & 12/15/08
ODG Guidelines and Treatment Guidelines
Authorization Requests: 12/05/08

Letter of Appeal: 12/05/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year old female receiving supervisor sustained an injury on xx/xx/xx when she was standing over a desk when some boxes suddenly fell on her back. The initial diagnosis was lumbar strain/sprain.

The claimant presented to Dr. on 03/05/07 with complaints of constant low back, coccyx and left gluteal pain radiating down her left lower leg which had increased over the past 2 weeks. A lumbar MRI performed on 04/27/05 revealed a disc herniation at L1-2 , a bone spur with bulging disc at L2-3 which resulted in flattening of the thecal sac and a minimal bulging disc at L4-5 with facet arthropathy. Exam findings revealed an antalgic gait on the left, active and reproducible trigger point tenderness to the quadratus lumborum, gluteus maximus and gluteus medius and limited lumbar range of motion secondary to pain. Additional findings included 2+ patellar and 1+ Achilles reflexes, Patrick's and piriformis caused coccyx pain with negative straight leg raise at 40 degrees as well as pain and numbness radiating down the left leg to the foot. The claimant was diagnosed with low back pain with left sided radiculopathy, L1-2 disc herniation, L2-3 bone spur with bulging disc and flattening of thecal sac, L4-5 minimal disc bulging with facet arthropathy, coccygodynia and myofascial pain syndrome. Conservative care included Flexeril, Skelaxin, Ultracet, Naproxen, Thera-Gesic cream, Toradol injections into trigger points for acute exacerbations, Tramadol, Neurontin, formal physical therapy, home exercise and stretching programs, activity modifications, light duty, and lumbar epidural steroid injections. Documentation from 05/17/07 revealed a 50 percent improvement of her symptoms with increased function and decreased use of medications following the initial epidural steroid injections. A letter of appeal dated 12/05/08 also revealed left groin pain with giveaway strength in the left lower extremity and outlined the claimant's documented radiculopathy, failed conservative treatment and positive results from diagnostic injections. Dr. requested authorization for a lumbar epidural steroid injection.

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

The evidence based ODG criteria suggests that individuals can be considered reasonable candidates for epidural steroid injections when they have documented findings of radiculopathy that has been unresponsive to conservative care. They can be considered candidates for repeat injections within the therapeutic phase if they achieve 50% to 70% pain relief. The criteria suggest that no more than two epidurals are typically recommended initially and rarely more than two for therapeutic treatment. This individual apparently went through two epidural steroid injections in the past. Reportedly, they achieved 50% pain relief. No further epidurals were requested at that time. More recently this individual has complained of progressively worsening back and left lower extremity pain. In review of the records it appears that this individual apparently has had ongoing back and lower extremity pain. While reportedly this individual saw improvement with the previous epidurals, the records do not necessarily reflect that as this individual is described as having persistent pain up to the severe level within months thereafter. Thus, it is unclear at this point in time, in the absence of meaningful long term improvement following the original series of injections that an additional epidural steroid injection would be considered medically necessary. There are no recent imaging

studies to confirm discrete neural compression. The previous imaging study did not document significant neural compression at a level that one might have predicted resulting in significant left lower extremity pain. This is based on an MRI report from 2005 that diagnosed nothing more than a minimal disc bulge at the L4-5 level. For the above stated reasons one cannot reasonably recommend an additional epidural steroid injection. The reviewer finds that medical necessity does not exist for Lumbar epidural steroid injection with fluoroscopy.

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)