Prime 400 LLC

An Independent Review Organization
240 Commercial Street, Suite D
Nevada City, CA 95959
Phone: (530) 554-4970
Fax: (530) 687-9015
Email: manager@prime400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
May/03/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Bilateral C4-C5 Transforminal Epidural Steroid Injection with Fluoroscopic/Outpatient

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
ODG TREATMENT GUIDELINES 2010
Denial Letters, 4/12/10, 3/15/10
M.D. 3/22/10, 2/22/10, 3/15/10
Diagnostic 8/21/09

PATIENT CLINICAL HISTORY SUMMARY
This patient has a history of “neck pain and bilateral upper extremity pain.” the documentation in the physical exam section showed that the patient had a negative Spurling’s sign. There was no cervical neurological exam documented. There is a mention of multiple movements of the neck that cause pain to radiate into the bilateral upper extremities. The exact location of this pain (i.e. is there a dermatomal pattern?) is not mentioned. The patient has failed physical therapy and medication management. The MRI of the cervical spine performed on 8/21/09 was significant for “mild degenerative disc disease… at the C4-5 level with a disc/osteophyte complex and a central disc protrusion. No central canal stenosis.” A letter written on 3/22/10 states that the patient is working full-time with no movement restrictions. There is mention that the patient “has pain with flexion of the knee.” Based on this, the letter states “for this reason, medical necessity has been

established." The letter goes on to say that "the patient gets more than 80 percent improvement in her symptomatology and is using less medications. We will go ahead and submit for a second injection." This is the first time that a second injection is mentioned. There is no documentation or mention of a date of service for a previous cervical ESI. The note also states that the OV note from 2/22/10 was not documented correctly. It states that the patient actually has a positive Spurling's sign (The side that is positive is not mentioned.). This "was missed on our dictation from the previous visit and at the present time."

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

Based on the information submitted, there are many reasons why this ESI is not indicated. Going on the assumption that this is a request for a second cervical ESI (as documented by the requesting physician), in order to satisfy ODG, the date in which the 1st ESI was performed and how long the patient's pain relief lasted would need to be documented. This information is necessary in order to decide if the request for a second ESI follows the ODG. In addition, the physical exam does not include enough detailed history to demonstrate whether or not the patient truly has radicular findings. The description of the patient's pain was not specific and therefore the MRI cannot be correlated with the patient's symptoms to see if the requested levels are appropriate. For all these reasons, the reviewer finds that medical necessity does not exist at this time for Bilateral C4-C5 Transforminal Epidural Steroid Injection with Fluoroscopic/Outpatient.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)