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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Translaminar ESI L5-S1 Bias To The Right

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

ODG

Dr. Office Visits, 12/21/09, 01/20/10, 02/17/10, 03/17/10

MRI cervical spine 01/18/10

Peer Reviews 03/01/10, 03/17/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male claimant with a reported injury date of xx/xx/xx and diagnosed with cervicgia and low back pain. The records indicated the claimant has severe neck pain and low back pain with radiating right leg pain. A lumbar MRI of an unknown date reportedly showed disc desiccation at L5-S1 with no evidence of foraminal encroachment. The records indicated that the claimant underwent a previous lumbar epidural steroid injection with a twenty percent reduction in pain. Conservative treatment also included medications. A repeat lumbar epidural steroid injection was recommended.

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

The requested lumbar epidural steroid injection L5-S1 is not medically necessary, based on review of this medical record. This is a male who was injured xx/xx, and has had back and intermittent leg symptoms. The 12/21/09 office visit of Dr. documents a lumbar MRI with L5-S1 degenerative changes, but there is no evidence of disc herniation or foraminal encroachment. It appears he had an epidural steroid injection with his pain reduced by 20 percent in the past, and they are requesting another lumbar injection. There is no documentation in this medical record of true neurologic deficits such as reflex change, numbness or sensation or true radicular pattern. There was a prior lumbar epidural steroid injection that was with minimal improvement. ODG Guidelines document the use of epidural steroid injections in claimants with documented radiculopathy, which has failed appropriate conservative care. There is no medical necessity for the injection because there is no documentation in the medical record of any true radicular neurologic deficit.

According to the records, the first injection did not provide at least 50 percent improvement

for six to eight weeks. The criteria for the use of Epidural steroid injections according to the Official Disability Guidelines is not satisfied. The reviewer find that medical necessity does not exist at this time for Lumbar Translaminar ESI L5-S1 Bias To The Right.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, : Low Back : Epidural steroid injections (ESIs), therapeutic

Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts

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.

(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 treatments

(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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)