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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/04/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Transforaminal injection right L4 under anesthesia with fluoroscopic guidance

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

MD, Board Certified in Pain Management and Anesthesiology

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

Official Disability Guidelines

MRI thoracic spine 10/28/09

MRI lumbar spine 10/28/09

Clinical note Dr. 06/08/11

Utilization review determination 06/09/11

Clinical note Dr. 06/21/11

Utilization review determination 06/23/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries to his low back on xx/xx/xx. The clinical records consist of a MRI thoracic spine dated 10/28/09 which shows mildly increased thoracic kyphosis. There is a slightly raised appearance of several of the mid thoracic vertebra around T4 through T7 at T5-6 there is an apparent small central disc herniation of approximately 2mm at T7-8 there appears to be a 3mm right paracentral disc herniation. A study of the lumbar spine was performed on this same date which notes there are no abnormalities at L1-2 and L2-3. At L3-4 there is disc space narrowing and decreased signal in the disc there is a midline annular tear and a 5mm diffused herniation with impression on the thecal sac. At L4-5 there is decreased signal and narrowing of that disc. There is a 6mm diffuse disc herniation with encroachment of both neural foramina more prominent on the right than the left at L5-S1 there is narrowing and decreased disc signal. There is a 5mm central and left paracentral disc herniation with mild foraminal encroachment.

On 06/08/11 the claimant was seen by Dr.. He is noted to have undergone three months of physical therapy with no significant relief of his pain. EMG is reported to show electrodiagnostic findings remarkable for an acute right L4 radiculopathy. He continues to experience low back pain, which is constant as well as extension of pain into the right lower

extremity in an L4 dermatome. He was recommended to undergo lumbar epidural steroid injections. Oxycontin is reported to control his pain levels however he is experiencing drowsiness. On physical examination he is noted to have tenderness to palpation of the lumbar paraspinal musculature greater on the right. He has a normal gait. He is independent with positional changes. He has decreased reflexes throughout and subsequently was recommended to undergo lumbar epidural steroid injection. On 06/09/11 this request was reviewed by Dr. who notes that the documentation does not support the request and notes that the injury is over 18 months of age specifics are not provided with regard to whether there have been previous attempts at treatment in the form of therapeutic injection. He notes at the present time the claimant does not meet criteria and therefore finds the request not to be medically necessary.

On 06/21/11 the claimant was seen by Dr. It's noted that the claimant has evidence of radiculopathy at L4 on the right. He's been unresponsive to NSAIDs and physical therapy for the last three months. Dr. notes that a request for a single level. On 06/23/11 the appeal request was reviewed by Dr. who notes that the request for transforaminal injection at the right L4 is not recommended as medically necessary. He notes that there's no comprehensive assessment of treatment completed to date or the claimant's response thereto. He notes that the claimant's physical examination does not establish the presence of an active lumbar radiculopathy and the electrodiagnostic study from which the request is based was not submitted for review.

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

The claimant is reported to have a right L4 radiculopathy, however the EMG/NCV study was not submitted as a supporting document. The claimant's imaging studies are consistent with the potential for a right L4 radiculopathy as well as L5 radiculopathy. On physical examination the claimant is noted to have tenderness, a normal gait, decreased reflexes throughout -- which is non-diagnostic with no evidence of sensory or motor strength loss. As such there is insufficient objective data to correlate with the claimant's subjective complaints imaging studies and electrodiagnostic studies to establish the presence of an active L4 radiculopathy and therefore the medical necessity of the request. The reviewer finds there is not medical necessity at this time for Transforaminal injection right L4 under anesthesia with fluoroscopic guidance.

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)