

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/09/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection L5-S1 Number #1

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

MD, Board Certified Anesthesiologist

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

Lumbar spine series 04/18/11

Office notes dated 04/22/11-06/22/11

Texas worker's compensation work status reports

MRI of lumbar spine without contrast on 04/26/11

Adverse determination letter, lumbar epidural steroid injection dated 06/24/11

Adverse determination letter, lumbar epidural steroid injection dated 07/21/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date he was working on when he awkwardly grabbed a pair of tongs that slipped then hit him in the back. MRI of the lumbar spine dated 04/26/11 revealed posterolateral L5-S1 HNP producing extradural S1 nerve root compression on the left. Note dated 06/06/11 reports that the patient is doing PT with some help. On physical examination gait is within normal limits. Strength is rated as 5/5. Sensation is decreased to sharp touch left S1 dermatome. Deep tendon reflexes are 2+ bilaterally. Straight leg raising is positive on the left at 30 degrees.

On 6/24/11, the peer reviewer noted that there is no objective evidence of radiculopathy on physical examination. This denial was upheld on 07/21/11. The reviewer stated that the medical records do not establish objective evidence of radiculopathy. The patient is a one pack per day smoker, and guidelines indicate that decreased success has been found in patients who smoke.

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

This patient's physical examination fails to establish the presence of active lumbar

radiculopathy as required by the Official Disability Guidelines. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has been unresponsive to conservative treatment as required by ODG. For these reasons, the reviewer finds there is not a medical necessity for Lumbar Epidural Steroid Injection L5-S1 Number #1, as the guidelines have not been satisfied.

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)