

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/01/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Transforaminal ESI, Left L4-5

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management

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

Notice of Case Assignment, 2/19/11
Official Disability Guidelines and Treatment Guidelines
Denial Letters, 1/20/11, 2/2/11
Management, P.A. 1/11/11-1/24/11
M.D. no date
Center 8/6/09

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was unloading electrical equipment from a work truck onto an 18-wheeler. He reports that he had one foot on the work truck and one foot on the 18-wheeler when he reached to grab some supplies and fell approximately five feet off the truck hitting the bumper and then the ground. MRI of the lumbar spine dated 08/06/09 revealed small central disc protrusion at L1-2 causing no stenosis or foraminal narrowing; central disc protrusion at L5-S1 with increased gray signal along the posterior rim; with the combination of the hypertrophy of the ligamentum flavum, 50% narrowing is seen bilaterally.

Office visit note dated 01/11/11 indicates that the patient complains of low back pain that radiates down the left lower extremity. Past treatments are noted to include physical therapy, epidural steroid injections and TENS unit. Current medications include Norco and Zanaflex. The patient underwent cervical laminectomy in 1996 and right ankle repair in 2003. On physical examination there is increased tenderness L2, L3 and L4. Neurological examination was normal. There is decreased sensation to pinprick in the left lateral calf. Deep tendon reflexes are 2+ and normal in the bilateral patella tendons.

Initial request for left L4-5 transforaminal epidural steroid injection was non-certified on 01/21/11 noting that there was no official MRI report submitted for review. The neurological exam showed no objective changes except for report of numbness of the lateral leg. There was no motor or reflex change. The denial was upheld on appeal dated 02/02/11 noting that no weakness or reflex changes were noted that would be consistent with lumbar radiculopathy. No electrodiagnostic studies were provided and clinical documentation is minimal regarding prior conservative therapy.

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

Based on the clinical information provided, the request for Transforaminal ESI, Left L4-5 is not medically necessary, and the two previous denials are upheld. The submitted record indicates that the patient has undergone epidural steroid injections in the past; however, there is no clinical information provided regarding these injections. The patient's physical examination does not establish the presence of active lumbar radiculopathy, and there are no electrodiagnostic results provided to support the diagnosis. Given the current clinical data, the requested Transforaminal ESI, Left L4-5 is not medically necessary at this time.

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)