

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/24/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar ESI under fluoroscopy with IV sedation 62311 77003

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Anesthesiology/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

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. He sustained injury to his neck, low back and right shoulder. Claimant sustained a minimally displaced comminuted fracture of the distal right clavicle. CT scan of the lumbar spine was performed on 06/15/11 and revealed grade 2 spondylolisthesis at L5-S1 with bilateral spondylosis and moderate to severe bilateral foraminal narrowing. At L4-5 there is 1-2mm of retrolisthesis of L4 on L5. Disc bulging is present at this level flattening of the ventral aspect of the thecal sac, but there does not appear to be nerve root swelling or displacement. Dr. saw the claimant for pain evaluation on 08/17/11. The claimant was noted to have chief complaint of chronic persistent back, left buttock and left leg pain associated with weakness, numbness and tingling. Dr. noted the claimant had undergone CT scan of the lumbar spine. Claimant also underwent EMG/NCV study of the lower extremities on 06/30/11, which revealed active, left S1 nerve root denervation process. Physical examination revealed the claimant to be 5'9" tall and 155 pounds. He walks with an antalgic limp and gait. Neuromuscular examination revealed

decreased lumbosacral flexion at 60 degrees with reproduction of back pain. He had moderate lumbar interspinous tenderness. He had moderate left sciatic notch tenderness with a positive straight leg raise sign on the left at 60 degrees and positive Lasegue's sign. He had a positive contralateral straight leg raise on the right. He had mild facet tenderness particularly over the left facet regions. SI joints were non-tender. No sudomotor or vasomotor changes were noted. Dr. recommended epidural steroid injection.

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

The claimant is noted to have sustained injuries on xx/xx/xx. He was treated by an orthopedic surgeon for clavicle fracture. However, there is no documentation presented that the claimant received conservative care for the low back such as physical therapy/exercise, anti-inflammatory or muscle relaxants. CT scan of the lumbar spine revealed 2-3mm disc bulge at L4-5 associated with flattening of the ventral aspect of the thecal sac with mild to moderate bilateral foraminal narrowing. At L5-S1 there is grade 2 spondylolisthesis with bilateral spondylosis, but no central canal stenosis. Electro diagnostic testing reported evidence of active left S1 nerve root denervation process, but the claimant was noted to have decreased pinprick sensation in the L4-5 distribution. The level or levels proposed for injection were not identified in the records presented for review. The reviewer finds there is not a medical necessity at this time for Lumbar ESI under fluoroscopy with IV sedation 62311 77003.

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)