

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/20/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

outpatient left L4-L5 transforaminal epidural steroid injection with fluoroscopy as relates to the lumbar spine

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

M.D., Board Certified Pain Medicine

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds that medical necessity does not exist for outpatient left L4-L5 transforaminal epidural steroid injection with fluoroscopy as relates to the lumbar spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Notice of utilization review findings 06/25/12
Notice of utilization review findings 07/11/12
Progress notes 04/09/12-07/24/12
MRI lumbar spine 02/21/12
History and physical 03/30/12
Physical therapy notes 05/21/12-07/17/12
Surgery pre-authorization request reconsideration 07/02/12
Drug screen urinalysis 07/10/12
Urine drug screen 04/12/12
Office notes 01/31/12-06/30/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a lifting injury to his low back. He complains of low back pain radiating to the left lower extremity. MRI of the lumbar spine on 02/21/12 revealed disc dehydration at L2-3, L3-4 and L4-5 with diminished disc space height at L4-5. There is a midline disc protrusion at L4-5 4-5mm in AP extent, which appears to extend into the right greater than left subarticular recess. There is mild to moderate central spinal stenosis without obvious foraminal stenosis. Generalized annular disc bulging is present at L3-4 with no definitive focal protrusion and no critical central or foraminal stenosis. He was treated conservatively with physical therapy and medications. He was seen on 06/19/12 at which time he presented with low back pain. His current pain was rated 10/10 on a scale of 1-10. He stated that the pain is worse than it was at the previous visit. He states the pain radiates to the bilateral leg and left greater than right numbness in both buttocks down the legs. He was treated with physical therapy and pain medication without significant improvement.

Physical examination reported lumbosacral spinal range of motion is mildly reduced with mild pain on range of motion. Straight leg raise test was positive bilaterally. Femoral stretch test was negative bilaterally. Faber test was negative bilaterally. Gaenslen test was negative bilaterally. Muscle strength was 5/5 in the bilateral lower extremities except toe extension 4/5 bilaterally. Sensation to light touch was impaired at the L5 or in the L5 dermatomal distribution bilaterally. Gait was antalgic. Transforaminal epidural steroid injection under fluoroscopy was recommended.

A request for outpatient left L4-5 transforaminal epidural steroid injection with fluoroscopy was denied per utilization review dated 06/25/12. The reviewer noted that the epidural steroid injection was proposed at a level different than the MRI disc herniation. Also there was no specific dermatomal pattern on neurological examination. A reconsideration request for outpatient left L4-5 transforaminal epidural steroid injection under fluoroscopy was denied 07/11/12. The reviewer noted there was unexplained change in neurological examination findings since March, three months after the work event. There do not appear to be any acute changes on MRI in a patient whose weight is perhaps 200 pounds over expected normal. He would be a technically demanding patient for epidural steroid injection. There does not appear to be evidence of a correlation between MRI findings and clinical findings. The absolutely symmetrical findings are not consistent with MRI findings.

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

The claimant sustained a lifting injury to the low back. He complains of low back pain radiating to the left greater than right lower extremity. MRI of the lumbar spine revealed multilevel degenerative changes with disc dehydration and a 4-5mm disc protrusion midline at L4-5 which appears to extend into the right greater than left subarticular recess with mild to moderate spinal stenosis without obvious foraminal stenosis. As noted on previous reviews, the physical examination does not correlate with imaging as the claimant reports left greater than right lower extremity pain whereas MRI reveals right greater than left pathology. The Official Disability Guidelines indicate that use of epidural steroid injection requires the presence of radiculopathy documented on physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There is no evidence of EMG/NCV with definitive evidence of radiculopathy. The reviewer finds that medical necessity does not exist for outpatient left L4-L5 transforaminal epidural steroid injection with fluoroscopy as relates to the lumbar spine.

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)