

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/11/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left C4 and C5 Cath Asst ESI w/EPI (62310 x 2)

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

M.D., Board Certified Anesthesiology; Board Certified 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the requested Left C4 and C5 Cath Asst ESI w/EPI (62310 x 2) is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes 02/09/07-07/25/12

Physical therapy progress reports and discharge summary 07/03/07-07/20/07 and 07/06/07

MRI cervical spine 07/12/12

Prior reviews 07/23/12 and 09/05/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx. Patient is status post anterior cervical discectomy and fusion and completed a physical therapy program in 07/07. There is a gap in clinical history from 2007 to 2012. Updated MRI of the cervical spine dated 07/12/12 revealed a prior anterior cervical fusion from C5 to C7. 2mm of anterolisthesis at T3-4 was noted. At C4-5 there was severe left foraminal stenosis secondary to annular disc bulging. Moderate to severe right foraminal stenosis was also noted as well as mild canal stenosis with absence of cord compression. The patient was evaluated on 07/25/12. Patient had complaints of headache neck stiffness and paresthesia in the left upper extremity. Physical examination the patient's current medications include Lyrica 75mg Lortab 10mg and Zanaflex 2mg. Other medications included Wellbutrin and Xanax XR. Physical examination revealed intact upper extremity reflexes with mild weakness noted at the left triceps left biceps. There was a sensory deficit noted in the left C7 dermatomal distribution. The patient was recommended for epidural steroid injections at C4-5. The request for C4 and C5 left epidural steroid injections was denied by utilization review on 07/23/12 as there was no clear evidence of radiculopathy on physical examination and no documentation of conservative measures. The request was again denied by utilization review on 09/05/12 as there was no documentation of conservative treatment and multiple injections were not recommended by

current evidence based guidelines.

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

The clinical documentation provided for review does not establish a clear diagnosis of cervical radiculopathy that would reasonably require epidural steroid injections. The patient is noted to have sensory loss in a C7 nerve root distribution, however there is no clear reflex changes or motor weakness consistent with the MRI findings at C4-5. Additionally there is insufficient clinical documentation regarding recent conservative treatment. The patient is currently taking muscle relaxers; however, there is no evidence of use of anti-inflammatories and no recent course of conservative treatment and there is no recent course of physical therapy documented that would meet guideline recommendations regarding conservative treatment prior to epidural steroid injections. The patient is documented only to have undergone a physical therapy program in 2007. Additionally the request for two separate epidural steroid injections is not supported as there is no clear indication that the patient has responded favorably to epidural steroid injections in the past. As the clinical documentation provided for review does not meet guideline recommendations, it is the opinion of the reviewer that the requested Left C4 and C5 Cath Asst ESI w/EPI (62310 x 2) is not medically necessary.

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)