

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/05/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L3/4 ESI

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

M.D., Board Certified Orthopedic Surgeon

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 Bilateral L3/4 ESI is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 07/13/12, 08/14/12
Office visit note dated 04/27/12, 04/10/12
Handwritten note dated 04/26/12, 05/07/12, 03/21/12
Follow up note dated 07/09/12, 06/18/12
Radiographic report dated 06/05/12
Operative report dated 06/05/12
Consultation dated 05/11/12
MRI lumbar spine dated 05/01/12
Office visit note dated 08/15/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male. He was reaching up to lift 30 lbs and felt a sharp pain in the low back. MRI of his lumbar spine dated 05/01/12 revealed severe facet arthropathy at L3-4; slight disc bulging and 2-3 mm of degenerative spondylolisthesis is present. Together those changes produce moderate canal stenosis; bilateral foraminal stenosis is present. Consultation dated 05/11/12 indicates that the patient has been to six sessions of physical therapy and has four more to go based on the current protocol. The patient was treated with left L3-4 transforaminal epidural steroid injection on 06/05/12. Follow up note dated 06/18/12 indicates that he got good relief initially with the injection for about a week and now the pain is coming back on the left side as well as on the right. Physical examination on 08/15/12

indicates that deep tendon reflexes note the left knee jerk is absent. The provider's request for bilateral L3-4 epidural steroid injection was denied on 07/13/12 noting that the claimant did not meet the Official Disability Guidelines criteria for epidural steroid injections. This denial was upheld on appeal dated 08/14/12 noting that there does not appear to be any additional information provided by the treating provider that would result in an overturn of the previous non-certification. The guidelines require objective evidence of radiculopathy, which needs to be corroborated by imaging studies and electrodiagnostic studies. The claimant has no objective signs of radiculopathy on physical examination with muscle atrophy or loss of relevant reflex. The MRI of the lumbar spine reported no nerve root compression. The guidelines state for repeat injections, there must be at least 50-70% pain relief obtained for at least six to eight weeks. In addition, there must be documentation of increased function and decreased reports of pain and decreased use of pain medications. The claimant has one week of relief after the previous injection. There is no documentation of increased function or decreased use of pain medications.

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

The submitted physical examination fails to establish the presence of active lumbar radiculopathy, as required by the Official Disability Guidelines. The patient underwent left L3-4 transforaminal epidural steroid injection on 06/05/12. Follow up note dated 06/18/12 indicates that he got good relief initially with the injection for about a week and now the pain is coming back on the left side as well as on the right. The Official Disability Guidelines support repeat epidural steroid injection with evidence of at least 50% pain relief for 6-8 weeks. It is the opinion of the reviewer that the requested Bilateral L3/4 ESI 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)