

# Core 400 LLC

An Independent Review Organization  
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**DATE OF REVIEW:**

May/15/2009

**IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Right SI/PSIS injection; pain management consult with Dr. Nguyen; physical therapy lumbar spine 2-3 x weekly x 6-8 weeks; Lumbar MRI with and without contrast; bilateral lower extremity EMG

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

M.D., board certified in Orthopedic Surgery

**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**

Determination Letters, 2/18/09, 3/4/09  
Patient Information Sheet, 2/17/08  
Spine Institute, Dr., MD, 2/21/08, 4/16/08, 8/28/08, 6/26/08, 1/29/09,  
Diagnostic Studies, 2/21/08  
Letter to, 2/21/08  
MRI of the Lumbar Spine, 3/19/08  
RME, 11/26/08  
Letter from addressing denial, 3/25/08  
ODG Guidelines and Treatment Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This man apparently was injured in xx-xxxx in a twisting injury. He had a previous disc surgery in 1991 and a laminectomy. He has had recent examinations that reveal that he has complaints of radiculopathy into the right lower extremity. He has had extensive physical therapy in the past. He has had SI joint injections with relief, and epidural steroid injections in the past. He has had an MRI in March 2008. He has had x-rays showing facet arthropathy and multi-level instability findings. The current request is for Right SI/PSIS injection; pain management consult with Dr. ; physical therapy lumbar spine 2-3 x weekly x 6-8 weeks; Lumbar MRI with and without contrast; and a bilateral lower extremity EMG.

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

This approach to the patient's diagnosis and treatment does not conform to the statutory

mandated ODG Official Disability Guidelines and Treatment Guidelines in the state of Texas. The diagnosis with the appropriate diagnostic studies has not been made prior to the recommendation for treatment options that are appropriate, given the diagnosis.

The reviewer finds that medical necessity does not exist for Right SI/PSIS injection, as this request does not meet the criteria established in the ODG. There is no documentation of recent conservative care, and the success or failure of that care. Upon examination, there are not three positive findings of SI joint dysfunction on exam, as required by the ODG.

The reviewer finds that medical necessity does not exist for pain management consult with Dr. There is no documentation of recent conservative care. The request for a pain management consult does not meet the guidelines.

The reviewer finds that medical necessity does not exist for physical therapy lumbar spine 2-3x weekly x 6-8 weeks. There is no information in the medical records describing in any detail those physical therapy sessions already completed by the patient. The request does not meet the guidelines, and the request exceeds the recommend number of sessions of therapy.

The reviewer finds that medical necessity does not exist for Lumbar MRI with and without contrast. There is no evidence of any new trauma. The request does not meet the guidelines, which state that repeat MRIs are only indicated if there has been progression of neurologic deficit.

The reviewer finds that medical necessity does not exist for bilateral lower extremity EMG. The reviewer agrees with the previous reviewer's assessment that there is no indication in the records of new onset of neurological symptoms or obvious progressive radicular findings. The guidelines do not support EMG if 4-6 weeks of aggressive conservative therapy have not been completed first. The request does not meet the guidelines.

The reviewer finds that medical necessity does not exist for Right SI/PSIS injection; pain management consult with Dr.; physical therapy lumbar spine 2-3 x weekly x 6-8 weeks; Lumbar MRI with and without contrast; bilateral lower extremity EMG.

**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)