

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lumbar epidural steroid injection

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

M.D., Board Certified in Anesthesiology and Pain Management
American Board of Anesthesiologists.

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

Official Disability Guidelines, Criteria for the use of Epidural steroid injections
Adverse Determination Letters, Specialty Risk Services, 9/2/10, 10/11/10
M.D. 3/12/08 to 10/29/10
Medical Centers 4/10/08
Diagnostic Center 12/1/08
Physical Therapy 8/4/08
7/27/07 to 11/13/07
Occupational Health Systems 5/4/10
M.D. 8/4/08

PATIENT CLINICAL HISTORY SUMMARY

This patient complains of "lower back pain and right leg pain" according to the 10/25/10 OV note. The dermatomal pattern of the right leg pain is not described. The physical exam on the same DOS (10/25/10) is significant for "straight leg raising is equivocal on the right at 60 degrees. Foraminal compression test is equivocal bilaterally... There is no evidence of atrophy. There is no evidence of dermatomal sensory deficits." Reflexes are equal bilaterally at the knees and ankles. An EMG/NCV from 8/4/08 was significant for "lumbar radiculopathy at the left L4-5 level," per the Peer review performed on 5/4/10 by Dr.. The EMG/NCV study was not included in the records. A MRI from 12/1/08 was significant for a broad-based 5mm posterior central disc protrusion at L4-5 with mild 2-3mm left paracentral/posterolateral disc bulge. It is also noted at L4-5 that, "there is no canal stenosis or right foraminal stenosis."

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

The Official Disability Guideline criteria for the use of Epidural steroid injections require that

“radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.” It is noted that this patient’s physical exam does not show any signs of radiculopathy. In addition, the EMG/NCV only shows problems on the left and not the right. The MRI does not show any abnormalities that can account for a right-sided radiculopathy. For these reasons the ODG criteria is not satisfied and the request for Lumbar epidural steroid injection is not medically necessary. The previous adverse determinations of 9/2/10 and 10/11/10 should be upheld.

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)