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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/07/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient lumbar epidural steroid injection (ESI) at L3-L4

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified in Neurological 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

Official Disability Guidelines
Adverse Determination Letters, 11/9/10, 11/17/10
Spine & Neurological Surgical Institute 10/26/10
Dr. 9/24/10 to 9/30/10
Imaging Center 10/6/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xx, sustained while restraining a patient. He complains of low back pain with radiation to the right waist. He also complains of bilateral leg numbness. He has undergone medications and physical therapy. His neurological examination 10/26/2010 reveals no significant abnormalities. An MRI of the lumbar spine 10/06/2010 shows at L2-L3: 1mm disc herniation with mild narrowing of the spinal canal. At L3-L4: 2mm diffuse disc herniation with mild narrowing of the canal and bilateral neuroforamina. At L4-L5: diffuse disc herniation of 2mm with mild narrowing of the spinal canal and bilateral neuroforamina. At L5-S1: 1mm disc herniation with mild narrowing of the spinal canal. The provider is recommending an outpatient lumbar epidural steroid injection (ESI) at L3-L4.

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

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The ESI at L3-L4 is not medically necessary. According to the ODG, "Low Back" chapter, "radiculopathy must be documented"

in order for an ESI to be medically necessary. In this case, there is no objective evidence of radiculopathy and no imaging evidence of nerve root compression. The claimant has nonspecific back pain. Therefore, based on the ODG and the records reviewed in this case, the reviewer finds no medical necessity at this time for Outpatient lumbar epidural steroid injection (ESI) at L3-L4.

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)