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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/03/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L4-L5 and L5-S1 Transforaminal Epidural Steroid Injection with Fluoroscopy

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

MD, Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 12/11/09, 12/29/09
Orthopaedic Surgery Group, 12/16/09, 11/23/09, 10/20/09, 8/11/09,
5/12/09, 2/5/09, 1/6/09
MRI Lumbar Spine, 2/3/09
Electromyography and NCV Study, 11/25/09

PATIENT CLINICAL HISTORY SUMMARY

This is a injured in an MVA on xx/xx/xx. Dr. wrote of his back pain and tingling in his legs. He had an MRI that showed degenerative changes in the discs. There was an EMG that failed to show any radiculopathy. Dr. wrote that there is pain radiating into the L4/5 dermatomes on SLR and Slump test. There is a request for ESI. The patient apparently had some therapy, but this was not documented in the records provided.

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

The patient has pain in his back and legs. The only description of a radicular pattern was with straight leg raising. There was no neurological loss described. The AMA Guides require documentation of a neurological loss, such as atrophy, abnormal reflexes, or sensory loss. None of these were described in the records. The MRI showed degenerative changes without

description of nerve root compression. Records indicate the patient has evidence of a radiculitis and not a radiculopathy. Therefore, he does not meet the ODG criteria for the ESI. There is no evidence or explanation provided in the records to support a divergence from the ODG. The reviewer finds that medical necessity does not exist for Right L4-L5 and L5-S1 Transforaminal Epidural Steroid Injection with Fluoroscopy.

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)

AMA Guides to the Evaluation of Permanent Impairment. 5th edition.