

# Core 400 LLC

An Independent Review Organization  
209 Finn St  
Lakeway, TX 78734  
Phone: (530) 554-4970  
Fax: (530) 687-8368  
Email: manager@core400.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jun/05/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Left ESI @ L5-S1 with fluoro 62311 72020 (J1040 J3490 A4550 77003)

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

MD, Board Certified in Physical Medicine and Rehabilitation.

**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**

Workers' Comp Services, 3/9/10, 3/29/10

D.O. 2/25/10, 3/11/10, 4/13/10

**PATIENT CLINICAL HISTORY SUMMARY**

This employee reported an injury xx/xx/xxxx. The mechanism of injury is not reported in the records. There is back pain and a positive straight leg raise. The patient did have an ESI on 2/25/10. There was 60% relief of pain according to a note of 3/11/10. The duration of pain relief is not known, but 14 days after the ESI she rated her pain as 5/10 on pain scale. The patient takes Lodine and Ultram. The dosages are not known. Previous PT notes are not available. It is not clear if patient is performing a home exercise program. It is not clear if there was functional change after the first ESI. The note of 4/13/10 states she has constant pain described as 2/10 to 9/10 pain scale.

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

The ODG indicates that ESIs can provide short term pain relief if there is evidence of radiculopathy and nerve compression so that patient is able to increase exercises and function. This patient has had one ESI, but there is not documentation of functional improvement, decrease in medications or the duration of relief of pain. Therefore, based on the provided information, another ESI is not supported by these notes at this time. The

reviewer finds that medical necessity does not exist at this time for Left ESI @ L5-S1 with fluoro 62311 72020 (J1040 J3490 A4550 77003).

**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)