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NOTICE OF INDEPENDENT REVIEW DECISION

Date of Notice of Decision: Nov/23/2010

DATE OF REVIEW: Nov/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L5-S1 Transforaminal Epidural Steroid Injection with Fluoroscopy

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

M.D., Board Certified in pain management and anesthesiology
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
9/9/10, 9/27/10
Imaging Services of El Paso 5/27/10
Surgery Group 6/14/10-11/1/10
4/14/10-9/27/10

PATIENT CLINICAL HISTORY SUMMARY

According to the 11/1/10 office visit note, this patient complains of "low back pain, bilateral lower extremity pain." There is no specific dermatomal pattern mentioned. The physical exam states that the straight leg raise (SLR) test is "positive at L4-5 and L5-S1 bilaterally with diminished sensation and strength 4/5." This documentation is not the standard way of documenting a SLR test and can therefore not be interpreted. A SLR test is either positive or negative. One is not able to specify a specific affected location or determine sensory perception or strength with this test. Documents from any neurological exam were not provided. A lumbar MRI from 5/27/10 stated that it was a "normal lumbar spine MRI." There was also a mention of a "3 mm disc osteophyte complex at the L5-S1 level." Dr. Viesca states that he does not agree with the radiologist's interpretation. He mentions that he sees an "extrusion/protrusion at the L5-S1 together with disk osteophyte complex."

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

ODG is clear that to meet criteria for ESI “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 the patient’s symptoms are not described sufficiently to determine if the patient’s pain is radicular. In addition, the documentation of the physical exam is not sufficient to back up radiculopathy. Even if it was, it could not be corroborated with the patient’s symptoms since they are not documented sufficiently. When reviewing Dr. interpretation of the MRI results from 9/17/10, it is noted that he does not mention the size of the “extrusion/protrusion.” This would also need to be clarified to determine if this is significant. The reviewer finds that medical necessity does not exist at this time for Bilateral 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)