

Core 400 LLC

An Independent Review Organization
7000 N Mopac Expressway, Suite 200
Austin, TX 78731
Phone: (512) 772-2865
Fax: (530) 687-8368
Email: manager@core400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/05/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient caudal epidural steroid injection (ESI)

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

M.D., Board Certified Orthopedic 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 and Treatment Guidelines

Utilization review determination dated 10/17/11, 11/07/11

Notice of employee's work related injury/illness dated xx/xx/xx

Radiographic report dated 07/28/11

MRI lumbar spine dated 09/07/11

Medical records ETMC- dated 07/27/11

Daily patient soap notes dated 08/17/11, 08/22/11, 08/26/11, 08/31/11, 09/02/11, 09/07/11, 09/12/11, 09/15/11, 09/20/11, 09/28/11, 10/05/11, 10/13/11, 10/19/11, 10/27/11

Injection scheduling form dated 09/26/11

Office visit note dated 09/26/11, 10/27/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. He slipped and fell on a wet floor. MRI of the lumbar spine dated 09/07/11 revealed minimal degenerative disc disease of L5-S1; a 2 mm broad based annular bulging disc resulting in 30-40% compromise of the foraminal canal bilaterally and facet arthropathy at L3-4. There is a 2 mm annular bulging disc with resulting 30-40% foraminal stenosis bilaterally and facet arthropathy at L4-5 and a 1-2 mm annular bulging disc at L5-S1. The patient underwent a course of physical therapy. Office visit note dated 10/27/11 indicates that the patient complains of pain in the low back that radiates to the right thigh. On physical examination the patient has full pain free range of motion of the bilateral lower extremities. Reflexes are symmetric. There is diminished light touch/pinprick right anteromedial leg/dorsum foot. Motor strength is rated as 5/5 throughout with the exception of -4/5 right EHL. Straight leg raising is negative.

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

The patient's physical examination fails to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines. The Official Disability Guidelines note that radiculopathy must be documented with objective findings on examination. The reviewer finds that the requested outpatient caudal epidural steroid injection (ESI) is not medically necessary.

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)