

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/03/2011

**IRO CASE #:**

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

Left L5-S1 outpatient caudal lumbar ESI

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

MD, Board Certified Anesthesiologist

**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-Treatment for Workers' Compensation

Utilization review determinations dated 04/01/11

Office visit note dated 12/01/10, 04/21/11, 03/28/11, 12/09/10, 08/31/10

Designated doctor evaluation dated 12/18/10

MRI of the lumbar spine dated 08/24/10

Physical therapy daily note dated 07/23/10

EMG/NCV dated 12/29/10

Physical therapy reevaluation dated 09/21/10

Functional capacity evaluation dated 12/28/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date he fell backwards. Treatment to date is noted to include physical therapy, epidural steroid injection x 2 and diagnostic testing. MRI of the lumbar spine dated 08/24/10 revealed desiccation and dehydration of the disc with posterocentral disc bulge at T11-12, L4-5 and L5-S1; bilateral foraminal stenosis at L5-S1, left more than right. The patient underwent epidural steroid injection on 12/01/10. Follow up note dated 12/09/10 indicates that the patient reports improvement in overall pain by less than half after the procedure. Designated doctor evaluation dated 12/18/10 indicates that the patient has reached MMI as of 12/18/10 with 10% whole person impairment. EMG/NCV dated 12/29/10 reported no evidence of L3-S1 radiculopathy. Functional capacity evaluation dated 12/28/10 indicates that the patient's current PDL is light medium. Office visit note dated 03/28/11 indicates that the patient reports 50% relief for greater than 2 months. Physical examination on 04/21/11 notes that heel and toe walking are poor. Deep tendon reflexes are diminished in the lower extremities. Straight leg raising is positive on the left. Sensory deficit is noted in the left L5 dermatome.

Initial request for left L5-S1 caudal lumbar epidural steroid injection was non-certified on 04/01/11 noting there is no documentation of a motor or sensory examination of the lumbar spine and lower extremities in the most recent report or no clear documentation of pain in a radicular pattern. It is not clear what level the prior epidural steroid injection was performed at. There is no documentation provided with regard to the failure of the patient to respond to conservative measures. The denial was upheld on appeal dated 04/29/11 noting active physical rehabilitative efforts may not have been maximized with only 5 PT visits as of the PT note dated 09/21/10. Maximized pharmacotherapy was not validated with pain and symptom logs. The lumbar MRI did not explicitly demonstrate the presence of frank nerve root involvement or impingement.

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

Based on the information provided, the reviewer finds that the request for Left L5-S1 outpatient caudal lumbar ESI is not medically necessary. There is no comprehensive assessment of treatment completed to date or the patient's response thereto to establish that the patient has been unresponsive to conservative treatment. The patient's physical examination fails to establish the presence of active lumbar radiculopathy, and the submitted EMG/NCV reports no evidence of L3-S1 radiculopathy. The submitted MRI does not explicitly demonstrate the presence of frank nerve root involvement or impingement. Therefore, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

**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)