

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** September/19/2011

**IRO CASE #:**

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

Repeat Lumbar ESI with Fluoroscopy 64483 77003, outpatient

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

MD, Board Certified Neurological Surgeon

**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

Clinical records Dr. 03/06/03-08/11/11

Request for IRO 08/25/11

Request for IRO 08/31/11

Utilization review determination 08/18/11

Utilization review determination 08/25/11

CT myelogram of lumbar spine 04/19/11

Operative report 03/12/03

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a male injured at work. He has chronic low back pain with radiation into right lower extremity. He failed conservative treatment. He had surgery on 03/12/03 and underwent a fusion procedure. Postoperatively the claimant is noted to have continued pain but was able to return to gainful employment. Historically he has had multiple CT myelograms of lumbar spine and he has been treated symptomatically with epidural steroid injections. More recent clinic notes indicate the claimant underwent lumbar epidural steroid injections in 2010, which provided approximately 6 months of relief. Clinic notes indicate on 02/11/11 the claimant underwent a repeat lumbar epidural steroid injection at L4-5. On 04/19/11 the claimant underwent CT myelogram of lumbar spine. This study notes a mild retrolisthesis of L4 on L5 with vacuum disc phenomena present. There are postoperative changes of PLIF at L5-S1 with interbody spacer and laminectomy present. The contrast column is noted to be faint. There is a mild loss of lumbar lordosis. There is poor visualization of nerve root sleeves at L4-5. Post myelogram CT notes disc bulge at L3-4 with facet hypertrophy and ligamentum flavum thickening resulting in mild spinal stenosis and foraminal encroachment. At L4-5 there is severe facet disease with broad based disc bulge and osteophyte with mild retrolisthesis of L4 on L5 producing mild spinal stenosis and moderate bilateral foraminal stenosis. At L5-S1 there are postoperative changes of PLIF without evidence of acute hardware complications. When seen in follow-up on 04/11/11 it is reported the claimant did not receive much benefit from right L4-5 epidural steroid injection. He is noted to be walking with flexed posture at the low back. He has decreased range of

motion. Straight leg raise was positive bilaterally. He has a somewhat wide based gait. He has depressed ankle reflexes and little weakness in plantar flexion and dorsiflexion to both feet. He was subsequently recommended to undergo a posterior L4-5 decompression, fusion and instrumentation. This apparently was not approved under utilization review. On 08/11/11 Dr. recommended the claimant undergo an L4-5 epidural steroid injection in the interval period.

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

The submitted clinical records indicate the claimant has undergone a single level lumbar fusion with instrumentation and has had continued low back pain with evidence of lumbar radiculopathy. The serial clinical records indicate the claimant has undergone epidural steroid injections in the past without sustained relief. Current evidence based guidelines require the claimant receive 50-70% relief for period of 6-8 weeks to establish medical necessity for repeat LESI. The submitted clinical records fail to establish the claimant met these criteria, and therefore the claimant would not be a candidate for repeat lumbar epidural steroid injections under the guidelines. The reviewer finds there is not a medical necessity for Repeat Lumbar ESI with Fluoroscopy 64483 77003, outpatient. Upon independent review, 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)