

Core 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: June/07/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP left L5 and S1 TF ESI with IV sedation/contrast/fluoro

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

M.D., Board Certified Anesthesiology/Pain Management

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
Lumbar MRI with 3D 08/04/08
Lumbar MRI dated 11/15/10
Pain management consultation dated 04/16/12
Utilization review determination dated 04/27/12
Letter of reconsideration dated 04/30/12
Utilization review determination dated 05/11/12

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male injured on xx/xx/xx. He was standing on some pipes when he lost his balance and was able to catch himself before falling. Lumbar MRI dated 08/04/08 revealed focal spondylosis change at L5-S1 with disc protrusion/extrusion and possible nerve root involvement; ligamentum flavum and facet hypertrophy lumbosacral junction. Lumbar MRI dated 11/15/10 revealed moderate loss of disc height at L5-S1 with posterior and right paracentral disc protrusion/extrusion measuring 9 mm anterior-posterior. Facet arthropathy is present with lateral recess stenosis on the right. There is minimal neural foraminal narrowing. Pain management consultation dated 04/16/12 indicates that treatment to date includes medication management and physical therapy. On physical examination he is completely unable to flex due to severe pain. Straight leg raising is positive on the left at 30 degrees and on the right at 70 degrees. Motor testing shows 3/5 weakness on left ankle dorsiflexion and plantar flexion. Neurosensory testing shows deficits in the L4, L5 and S1 dermatomes of his left calf to pinwheel exam. Deep tendon reflexes are 2+ in the right Achilles and 1+ in the left Achilles. Current medications are over the counter ibuprofen and Tylenol.

Initial request for left L5 and S1 TF epidural steroid injection was non-certified on 04/27/12

noting that per designated doctor evaluation, the patient was determined to have reached maximum medical improvement as of 07/12/11 with 5% whole person impairment. The patient's clinical exam does not correlate with imaging study findings as MRI showed right-sided disc pathology at L5-S1, but the patient's exam findings are all left sided. The denial was upheld on appeal dated 05/11/12 noting that no physical therapy notes were submitted for review to indicate how many physical therapy sessions the patient has had to date along with failure of conservative treatment. There is lack of a rationale to support the necessity of IV sedation during the epidural steroid injection procedure.

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

There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has been unresponsive to conservative treatment. The patient's physical examination findings do not correlate with MRI findings as MRI showed right-sided disc pathology at L5-S1, but the patient's exam findings are all left sided. The ODG criteria for the requested procedure is not satisfied. The reviewer finds there is no medical necessity for OP left L5 and S1 TF ESI with IV sedation/contrast/fluoro.

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)