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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: thoracic epidural steroid injection #1 @ T7-8 using fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for thoracic epidural steroid injection #1 @ T7-8 using fluoroscopy is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 05/31/13, 07/15/13
Visit note dated 05/06/13
MRI thoracic spine dated 05/02/13
Letter of medical necessity dated 06/14/13
Office note dated 05/17/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. Since performing that activity she has experienced sharp neck and back pain that radiated down her right arm and leg and around her ribs on the right side. MRI of the thoracic spine dated 05/02/13 revealed at T7-8 there is a small right paracentral and foraminal disc extrusion extending superiorly from the disc space level and mildly effacing the ventral thecal sac. The disc extrusion measures up to 2 mm AP by 4 mm transverse by 10 mm craniocaudal. There is mild right neural foraminal narrowing at T7-8 and no spinal canal stenosis. Visit note dated 05/06/13 indicates that treatment to date includes thoracic MRI. On physical examination cervical range of motion is flexion 45, extension 40 degrees. There is tenderness to palpation over T5, T6, T7, and T8. Lumbar range of motion is flexion 70 and extension 15 degrees. Straight leg raising is negative on the left and positive on the right at 60 degrees. Note dated 05/17/13 indicates that the patient has had approximately 3-4 sessions of physical therapy. Medications are listed as Norco, Lodine and Robaxin. On physical examination deep tendon reflexes in the upper extremities are normal and symmetric bilaterally. Sensation and strength are also normal. Lower extremity deep tendon reflexes are normal and symmetric; strength and sensation are intact. Letter of medical necessity dated 06/14/13 indicates that the patient has completed 3 sessions of physical

therapy.

Initial request was non-certified on 05/31/13 noting that the records available for review do not document the presence of any radicular symptoms on physical examination and additionally, a thoracic MRI accomplished after the date of injury did not reveal the presence of a compressive lesion upon a neural element in the lumbar spine.

The denial was upheld on appeal dated 07/15/13 noting that the claimant was noted to have some mild right neural foraminal stenosis at T7-8 level; however, the major complaint appears to be low back pain, right leg symptoms and right arm symptoms which do not appear related to the incidental disc protrusion noted on the MRI. Lower levels of care have not been exhausted as the claimant has only participated in three formal physical therapy sessions to date, and it does not appear the T7-8 disc is the primary causative factor in the claimant's complaints of pain.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on xx/xx/xx and has completed only 3 physical therapy visits to date. The Official Disability Guidelines support epidural steroid injection only for patients with documented radiculopathy who have been unresponsive to lower levels of care. Radiculopathy must be documented on physical examination and corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active radiculopathy, and the submitted MRI fails to document any significant neurocompressive pathology. As such, it is the opinion of the reviewer that the request for thoracic epidural steroid injection #1 @ T7-8 using fluoroscopy is not recommended as 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)