

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Nov/07/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** O/P ASC caudal ESI w/catheter @ L4-5

**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 requested O/P ASC caudal ESI w/catheter @ L4-5 is not recommended as medically necessary.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Clinical note 09/12/12  
Clinical note 12/05/12  
Clinical note 01/18/13  
Clinical note 02/15/13  
Clinical note 03/15/13  
Clinical note 04/26/13  
Clinical note 06/25/13  
Clinical note 07/05/13  
Clinical note 08/12/13  
Clinical note 09/16/13  
Clinical note 10/21/13  
Operative note 05/22/13  
Adverse determinations dated 08/19/13 and 10/01/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his low back from an unknown origin. Clinical note dated 09/12/12 indicated the patient presenting with CT myelogram which revealed a congenitally narrowing spinal canal. No disc herniation or significant disc bulge was noted. No stenosis of the nerve roots was noted. Clinical note dated 12/05/12 indicated the patient undergoing facet injection at L4-5 and L5-S1 on the right which provided five months of pain relief. The patient was recommended for L3 through S1 medial branch block; however, the patient was not in compliance with the proposed procedure. Clinical note dated 01/18/13 indicated the patient stating the initial injury occurred on xx/xx/xx. The patient stated he experienced sudden and severe low back

pain. The patient rated the pain as 10/10 with a burning quality and occasional numbness. MRI in 07/12 revealed L4-5 disc desiccation with a right paracentral annular tear. The patient underwent epidural steroid injection in 07/11 and medial branch block and subsequent radiofrequency ablations most recently on 05/07/10. No strength, sensation, or reflex deficits were noted at this time. Clinical note dated 04/26/13 indicated the patient undergoing medial branch block in 03/13 bilaterally at L4-5 and L5-S1. The patient reported 80% relief for six hours. Procedure note dated 05/22/13 indicated the patient undergoing bilateral medial branch rhizotomy at L3 through L5. Clinical note dated 06/25/13 indicated the patient report a 70% improvement in his pain level following the rhizotomy. The patient had not tried physical therapy to date. The patient had diminished sensation over the right medial and lateral thigh and lateral aspect of the foot. Clinical note dated 07/05/13 indicated the patient complaining of 8/10 pain. EMG in 06/13 revealed evidence of old S1 radiculopathy. The patient continued with 50% reduction in pain following the previous facet injections. Upon exam the patient demonstrated 30 degrees of lumbar flexion and 10 degrees of extension. Straight leg raise was positive on the right. The patient was provided with trigger point injections in bilateral lower extremities at this time. Clinical note dated 08/12/13 indicated the patient continuing with a sharp, stabbing, burning like discomfort in the low back with pain radiating into the bilateral lower extremities on the right greater than the left. Upon exam sensation was intact in the lower extremities. Reflexes were within normal limits. Clinical note dated 09/16/13 indicated the patient complaining of numbness and tingling in the bilateral lower extremities. No weakness was noted. The patient utilized Norco for ongoing pain relief. Prior utilization review dated 08/19/13 revealed no imaging or electrodiagnostic studies confirming L4-5 radiculopathy. No records were support submitted supporting the previous completion of a course of physical therapy. Prior utilization review dated 10/01/13 resulted in denial for epidural steroid injection L4-5 as no information was submitted regarding objective findings confirming evidence of radiculopathy. No documentation was submitted confirming completion of conservative care.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** Clinical documentation submitted for review complaining of low back pain with associated sensation deficits in the lower extremities. Epidural steroid injection would be indicated provided that the patient meets specific criteria, including completion of all conservative treatment and imaging studies confirming neurocompressive findings. Clinical notes mention the previous MRI in 2010. However, no information was submitted confirming L4-5 pathology. No information was submitted regarding recent completion of a full course of conservative treatment addressing low back complaints. As such, it is the opinion of the reviewer that the requested O/P ASC caudal ESI w/catheter @ L4-5 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)