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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/22/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L L4-5, L5-S1 TF ESI - Lumbar transforaminal – epidurography/radiology/anesthesia

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: .M.D., Board Certified Anesthesiology 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 this reviewer's opinion that medical necessity for the requested L L4-5, L5-S1 TF ESI - Lumbar transforaminal – epidurography/radiology/anesthesia is not established

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical reports dated 04/01/13 & 05/22/13
MRI of the lumbar spine dated 05/03/13
Prior reviews dated 06/03/13 & 06/17/13
Drug screen report dated 05/28/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury on xx/xx/xx and has been followed for complaints of low back pain and groin pain. Per the clinical report on 04/01/13, the patient slipped. The patient reported severe continuous low back pain rating 10/10 on the VAS scale. There was no description of any lower extremity symptoms. The patient's physical examination demonstrated tenderness to palpation in the lumbar spine with loss of lumbar range of motion. Supine and straight leg raise testing was reported as positive to the right at 55 degrees reproducing low back pain only. The patient was performed heel and toe walking with difficulty. The patient was recommended for conservative treatment to include physical therapy. MRI studies of the lumbar spine completed on 05/03/13 showed a disc extrusion measuring 6mm at L4-5 with compression of the thecal sac and L5 nerve root sleeves. At L5-S1, there was a 5mm disc extrusion compressing the right S1 nerve root with flattening of the thecal sac. Moderate canal stenosis at L5-S1 was present. The clinical report on 05/22/13 indicated the patient continued to have low back pain with cramping feelings in the lower extremities bilaterally. No current medications were noted on the evaluation. The patient's physical examination was limited with no specific exam findings noted. The patient was recommended for L4-5 and L5-S1 epidural steroid injections. The patient was reported to have no response to conventional non-invasive treatments to include physical therapy or the use of medications.

The request for L4-5 and L5-S1 epidural steroid injections performed transforaminally was denied by utilization review on 06/03/13 as there were no clear symptoms or physical examination findings to suggest the presence of a lumbar radiculopathy.

The request was again denied by utilization review on 06/17/13 as there were no objective findings consistent with a radicular component.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for complaints of low back pain with cramping reports in the lower extremities. No symptoms in a dermatomal distribution were identified on the most recent evaluation. Furthermore, the patient's last evaluation in May of 2013 did not provide any in depth neurological evaluation showing evidence of motor weakness, reflex changes, or sensory deficits that correlate with MRI findings. Given the absence of clear objective findings to support a diagnosis of lumbar radiculopathy as recommended by current evidence based guidelines, the proposed epidural steroid injections at L4-5 and L5-S1 would not be supported per guideline recommendations. As such, it is this reviewer's opinion that medical necessity for the requested L L4-5, L5-S1 TF ESI - Lumbar transforaminal – epidurography/radiology/anesthesia is not established and the prior denials are 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)