

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Oct/23/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** lumbar ESI caudal approach with fluoroscopy

**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 the opinion of the reviewer that the request for lumbar ESI caudal approach with fluoroscopy is not recommended as medically necessary.

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who sustained an injury on xx/xx/xx. The patient sustained multiple injuries which have required multiple surgical procedures for the right knee. It is noted that the patient is status post lumbar decompression at L4-5 with facetectomy and total discectomy followed by posterior lumbar interbody fusion with instrumentation completed on 10/21/10. Following surgery the patient was seen for continuing chronic complaints of low back pain. The patient is noted to have received a recent caudal epidural steroid injection on 07/18/14. There was a clinical report from 08/14/14 noting that the last injection did provide benefit in regards to the patient's low back and right lower extremity symptoms. Overall, the patient indicated that he had improved by approximately 80%. On physical examination the patient did have minimal tenderness to palpation of the lumbar region. The patient was recommended for a repeat caudal epidural steroid injection. The requested caudal epidural steroid injection was initially denied on 09/09/14 as it was unclear what date the epidural steroid injection had been performed on as well as indication of duration of relief as well as objective functional improvement following the injection. There was also minimal evidence regarding continuing radiculopathy that would support further injections. The request was again denied on 09/26/14 due to the lack of any evidence regarding lumbar radiculopathy.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been followed for continuing complaints of chronic low back and radicular pain following a single level lumbar decompression and fusion in 2010. The patient is noted to have received a caudal epidural steroid injection in July of 2014 with the most recent clinical report dated 08/14/14 noting approximately 80% relief from the injection. Based on the date of service, this was more than

6 weeks of relief. The patient's physical examination did note minimal tenderness in the lumbar area; however, the clinical documentation did not discuss any specific functional improvement or reduction in medications as it is noted the patient was previously being prescribed Tramadol for pain. Per guidelines, there should be documentation regarding both functional improvement and reduction of pain medications in addition to documentation regarding the amount of pain relief. Guidelines also do not recommend a series of epidural steroid injections to address lumbar radicular complaints. The most recent evaluation provided no objective evidence regarding continuing radiculopathy that would support an additional injection based on guideline recommendations. As such, it is the opinion of the reviewer that the request for lumbar ESI caudal approach with fluoroscopy is not recommended as medically necessary. 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 KNOWLEDGBASE

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)