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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/21/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right L5-S1 transforaminal ESI w/selective nerve root block

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery, Fellowship Trained Spine Surgery

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 right L5-S1 transforaminal ESI w/selective nerve root block is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient lost his balance on some stairs and fell forward, twisting his back and landing on his outstretched hands in a push-up position. Lumbar MRI dated 09/26/13 revealed at L5-S1 there is an 8 mm left subarticular disc protrusion/extrusion with marked impingement on the lateral recess in the region of the S1 nerve root. There is mild facet arthrosis with osteophytic ridging and disc bulging with mild canal and moderate foraminal stenosis. Note dated 12/02/13 indicates that the patient underwent left sided L5-S1 transforaminal epidural steroid injection with S1 selective nerve root block on 11/14/13 without any improvement of his symptoms at any point. Note dated 12/30/13 indicates that the patient has been attending physical therapy for the shoulders for the past two weeks. Note dated 03/18/14 indicates that straight leg raising is positive on the left. There is a diminished bilateral Achilles reflex. Motor exam is normal in the lower extremities. Note dated 04/14/14 indicates that the patient is status post left shoulder arthroscopy on 04/10/14.

Initial request for right L5-S1 transforaminal epidural steroid injection with selective nerve root block was non-certified on 02/24/14 noting that the patient underwent an epidural steroid injection on 01/30/14. Objective documentation of whether this injection was performed and any associated response to the injection was not noted in the records provided for review. The guidelines would not support repeat epidural steroid injection without objective documentation of pain relief of 50-70% for 6 to 8 weeks with decreased medication use and increased function as well as decreased pain scores. Recent documentation of conservative treatment failure has not been noted. Clinical evidence of radiculopathy with correlation on

imaging was not provided to support an epidural steroid injection.

The denial was upheld on appeal dated 04/04/14 noting that there is no documentation of objective evidence of radiculopathy on physical examination or nerve root compromise by diagnostic imaging as required. There is no documentation of lower levels of care. A home exercise program was not documented. There is no indication that the claimant had required relief after the previous epidural steroid injection.

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 underwent a left sided epidural steroid injection with S1 selective nerve root block on 11/14/13 without any improvement of his symptoms. It appears that he underwent an epidural steroid injection on 01/30/14; however, there is no information provided regarding this injection. The Official Disability Guidelines require documentation of at least 50% pain relief for at least 6 weeks prior to repeat epidural steroid injection. The patient's physical examination fails to establish the presence of active lumbar radiculopathy as required by the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for right L5-S1 transforaminal ESI w/selective nerve root block 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)