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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/26/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: OP lumbar epidural steroid injection @ L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Neurological 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 OP lumbar epidural steroid injection @ L5-S1 is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization reviews dated 12/30/13, 01/28/14
Progress note dated 11/06/13, 01/16/14, 06/26/13, 10/01/13, 08/16/13, 07/12/13
MRI of the lumbar spine dated 07/18/13
SOAP note dated 01/07/14, 12/17/13, 01/28/14, 01/21/14,
Office visit note dated 09/24/13, 08/06/13
Operative report dated 09/12/13
X-ray of the lumbar spine dated 06/20/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient was seen and assessed with lumbar sprain/strain and contusion of buttock. MRI of the lumbar spine dated 07/18/13 revealed at L5-S1 there is a central/bilateral paracentral focal disc protrusion/subligamentous herniation measuring 18 mm in transverse by 4 mm in AP, resulting in moderate to severe bilateral lateral recess stenosis and compression of S1 nerve roots. There is bilateral facet hypertrophy, along with bulging of the disc resulting in mild bilateral foraminal stenosis without nerve root compression. Note dated 08/06/13 indicates that the patient has done 8 sessions of physical therapy with no improvement. The patient underwent lumbar epidural steroid injection on 09/12/13. Note dated 09/24/13 indicates that he reports improvement after the injection. Note dated 10/01/13 indicates that the pain is slowly starting to creep back, but not as bad as it had been. Follow up note dated 01/16/14 indicates that pain level is 6/10. Medications are listed as cyclobenzaprine, metformin, naproxen and simvastatin. On physical examination seated straight leg raising causes pain behind the right upper leg at 30 degrees, left side negative for pain. Strength is normal in the lower extremities. Deep tendon reflexes are 2 bilaterally. Sensation is intact in the lower extremities.

Initial request for OP lumbar epidural steroid injection at L5-S1 was non-certified on 12/30/13 noting that the patient has undergone a prior lumbar epidural steroid injection with some noted benefit; however, there is a lack of quantified pain relief and duration of pain relief indicated from the prior injection. Additionally, there is a lack of documentation indicating overall improvement and function with objective measurement and to indicate if the patient had a decreased need for medications following the prior injection. The denial was upheld on appeal dated 01/28/14 noting that the intended laterality for the requested ESI was not specified. There is a need to indicate what type of spinal injection this patient previously had, as it is uncertain if this was an ESI. Furthermore, updated documentation still failed to address the prior issues for non-certification, which are still unresolved.

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 secondary to a slip and fall. The patient underwent prior epidural steroid injection on 09/12/13. The Official Disability Guidelines require documentation of at least 50% pain relief for at least 6 weeks prior to the performance of repeat epidural steroid injection. The submitted records fail to provide documentation that meets this requirement. As such, it is the opinion of the reviewer that the request for OP lumbar epidural steroid injection @ L5-S1 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)