

Core 400 LLC

An Independent Review Organization
3801 N Capital of TX Hwy Ste E-240 PMB 139
Austin, TX 78746-1482
Phone: (512) 772-2865
Fax: (530) 687-8368
Email: manager@core400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/09/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar epidural steroid injection at left L4-5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Anesthesiology

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.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. On this date he was involved in a motor vehicle accident. The patient sustained a right eye orbit fracture, nose fracture and right shoulder labrum tear. The patient also complained of low back pain. MRI of the lumbar spine dated 12/18/13 revealed at L4-5 there is posterior subligamentous disc herniation measuring 5-6 mm creating mild to moderate central spinal canal stenosis. The patient underwent a course of physical therapy. EMG/NCV dated 06/18/14 revealed evidence consistent with left S1 radiculopathy with both acute and chronic denervation changes. Physical examination on 06/18/14 notes decreased sensation left L4, L5 and S1. Tone is normal Strength is 5/5 throughout.

Initial request for lumbar epidural steroid injection at left L4-5 was non-certified noting that the clinical documentation submitted for review does support that the patient has been treated conservatively for this injury. However, there are no documented clinical findings of radiculopathy. There are no physical findings provided by the requesting provider in over a month. The denial was upheld on appeal dated 08/27/14 noting that the MRI reported no nerve root impingement. There is no documentation of lower levels of care including a home exercise program or use of non-steroidal anti-inflammatories or muscle relaxants.

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 when he was involved in a motor vehicle accident. The submitted records fail to establish that the patient has been unresponsive to conservative treatment as required by the Official Disability Guidelines. Additionally, there is no current, detailed physical examination submitted for review 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 lumbar epidural steroid injection at left 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)