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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/27/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: transforaminal epidural steroid injection @ left L3-L4

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 transforaminal epidural steroid injection @ left L3-L4 is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as a slip and fall. He injured his left arm and low back. MRI of the lumbar spine dated 12/28/12 revealed at L3-4 there is degenerative disc desiccation and a left lateralizing disc-osteophyte complex that causes stenosis of the left lateral recess, in conjunction with moderate facet arthrosis and ligamentum flavum thickening. There is equivocal mass effect on the passing left L4 nerve root. The left neural foramen is also moderately narrowed without compelling nerve root compression. The central canal and right neural foramen remain patent. EMG/NCV dated 10/08/13 revealed evidence consistent with L5-S1 lumbar radiculopathy. Progress note dated 05/13/14 indicates that he has not had any prior treatment for back pain and leg numbness. The patient did have a week of physical therapy, mainly for his left shoulder, and he did undergo left shoulder surgery. Progress note dated 08/05/14 indicates that recent treatment has consisted of medications. On physical examination there is left paralumbar tenderness to palpation. Lumbar range of motion is moderately limited in each direction. Straight leg raising is positive to the foot with any motion off the floor, completely negative on the right. Sensation is decreased in the left lower extremity lateral calf and dorsal/lateral aspects of the foot.

Initial request for transforaminal epidural steroid injection at left L3-4 was non-certified on 07/07/14 noting that the medical records from 4 different health care providers document completely different physical examination findings. There is poor inter-observer consistency. However, three providers document essentially normal lower extremity neurological examinations. The lumbar MRI shows degenerative pathology, not acute neurocompressive pathology, which is not amenable to treatment with epidural steroid injections. The denial was upheld on appeal dated 07/31/14 noting that the MRI documents disc osteophyte complexes that are consistent with old pre-existing pathology.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient's MRI fails to document significant neurocompressive pathology at the requested level, and EMG/NCV documents findings consistent with lumbar radiculopathy at L5-S1, not L3-4. There is no indication that the patient has undergone any recent conservative treatment for complaints of low back pain and leg pain. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. There must also be failure of conservative treatment prior to epidural steroid injection. As such, it is the opinion of the reviewer that the request for transforaminal epidural steroid injection @ left L3-L4 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)