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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/05/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right transforaminal epidural steroid injection at L5-S1 level under fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic 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 transforaminal epidural steroid injection at L5-S1 level under fluoroscopy is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient was involved in a motor vehicle accident. CT of the lumbar spine dated xx/xx/xx revealed small posterior disc bulges at L3-4 and L4-5. EMG/NCV dated 01/23/14 revealed prolonged distal latency of the left median motor nerve; otherwise normal study. MRI of the lumbar spine dated 02/07/14 revealed at L5-S1 there is moderate hypertrophy of the posterior facet joints. No HNP or spinal stenosis is identified. The patient underwent a course of physical therapy x 6 sessions. Office visit note dated 05/21/14 indicates that back pain is worse than radicular right-sided lower extremity pain that goes no further than the knee. On physical examination straight leg raising is negative bilaterally. Lower extremity motor strength is 5/5 with the exception of 4+/5 tibialis anterior. There is decreased sensation right sided L5 dermatomal pattern. Note dated 06/23/14 indicates that diagnoses are spinal stenosis in cervical region, displacement lumbar intervertebral disc without myelopathy, and low back pain.

Initial request for right transforaminal epidural steroid injection at L5-S1 level under fluoroscopy was non-certified on 07/18/14 noting that the clinical documentation does support that the patient has ongoing pain complaints at the lumbar spine that have failed to respond to 6 visits of physical therapy and medications. However, the patient's most recent clinical evaluation does not provide any objective evidence of radiculopathy. The most recent MRI submitted does not provide any nerve root pathology.

The denial was upheld on appeal dated 08/11/14 noting that the most recent clinical reports did not indicate the presence of objective findings consistent with radiculopathy at the right L5-S1. A recent imaging and/or electrodiagnostic study that provides objective evidence of radiculopathy and/or frank nerve root impingement at the requested level was not presented.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in xx/xxxx and has completed only 6 sessions of physical therapy. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active lumbar radiculopathy, and the submitted lumbar MRI fails to document any significant neurocompressive pathology at the requested level. As such, it is the opinion of the reviewer that the request for right transforaminal epidural steroid injection at L5-S1 level under fluoroscopy 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)