

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

DATE NOTICE SENT TO ALL PARTIES: Nov/02/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lumbar epidural steroid injection under fluoroscopy, L4-5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Anesthesiologist

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 lumbar epidural steroid injection under fluoroscopy, L4-5 is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is XX/XX/XX. fell back and she felt a jerk in her back. CT of the lumbar spine dated xxxx revealed at L4-5 there is moderate to severe bilateral facet degeneration with a minimal disc bulge and prominence of ligamentum flavum. There is overall mild to moderate bilateral foraminal narrowing and mild vertebral canal narrowing. Progress note dated xxxxx indicates that she tried physical therapy but could not tolerate it due to pain. Progress note dated xxxx indicates that the patient is unable to work due to dysfunction. The patient complains of low back pain rated as 4/10. The patient lacks an appropriate home exercise program. Diagnoses are sprain of ligaments of thoracic spine, low back pain, displacement of thoracic intervertebral disc without myelopathy, spinal stenosis and lumbago. The patient reports an increase in functional ability over the past few weeks. On physical examination strength is decreased throughout the lower extremities. Further skilled physical therapy was recommended to address strength, pain and decreased function.

Request for lumbar epidural steroid injection under fluoroscopy L4 5 was non-certified on xxxxx noting that clarification as to the laterality of the epidural steroid injection is needed. Documentation of exhaustion of conservative methods prior to this request was not clearly specified.

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. The Official Disability Guidelines require documentation that a patient was initially unresponsive to conservative treatment. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. 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 radiculopathy. As such, it is the opinion of the reviewer that the request for lumbar epidural steroid injection under fluoroscopy, L4-5

is not recommended as medically necessary and the prior denials are upheld.

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)