

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: November 30, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injection at L3-4 under fluoroscopy with IV sedation.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in 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)

The requested service, lumbar epidural steroid injection at L3-4 under fluoroscopy with IV sedation, is medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 11/4/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/5/10.
3. TDI Notice to IRO of Case Assignment dated 11/8/10.
4. Medical records from DO dated 6/7/10, 7/28/10, 8/30/10, and 9/30/10.
5. MRI of the Lumbar Spine without Contrast dated 11/18/09.
6. Operative report from MD dated 3/5/10.
7. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

A female patient is seeking coverage for lumbar epidural steroid injection at L3-4 under fluoroscopy with IV sedation. The Carrier has denied this request indicating that the requested services are not medically necessary for treatment of the patient's lumbar disc protrusion and persistent leg pain. A review of the record indicates the patient has moderate pain in her lumbar area radiating into her right buttock and right lateral knee. The provider indicates this is associated with a positive straight leg raising sign consistent with a disc disruption at the L3-4 interspace. The patient has had epidural injections in the past with documented relief. The provider has recommended injection therapy with epidural at the L3-4 interspace under fluoroscopy with IV sedation. The Carrier has denied this request based on the following: the patient has already received two epidural steroid injections; imaging shows no clear neurocompression at these levels; there is a clear rating indication of pain improvement; there is no documentation of return to work, decreased medications, etc; and there is no mention of objective signs of radiculopathy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

I have determined that lumbar epidural steroid injection at L3-4 under fluoroscopy with IV sedation is medically necessary for treatment of the patient's medical condition. This patient has had successful epidural steroid injections in the past with documented efficacy rates of 75% to 100%. On examination, range of motion is restricted. Straight leg raising is positive with radicular complaints in the distribution of the L3 nerve root. Further, there is documented evidence of a spinal lesion at the L3-4 level. All told, epidural steroid injection at L3-4 under fluoroscopy with IV sedation is medically indicated for this particular patient given the patient's documented history and findings. The requested service is consistent with accepted medical standards in this setting.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)