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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:** August 2, 2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Transforaminal epidural steroid injection (64483, 77003, 72100, 99144).

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

**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, transforaminal epidural steroid injection (64483, 77003, 72100, 99144), is not medically necessary for treatment of the patient's medical condition.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Medical records from DO dated 2/17/11, 3/24/11, 4/15/11, 5/12/11, 5/19/11, and 6/23/11.
2. MRI of brain with and without contrast dated 3/23/11.
3. MRI of lumbar spine dated 9/15/10.
4. Operative reports dated 1/28/11 and 4/11/11.
5. Denial Documentation.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female whose physician is requesting authorization for a third transforaminal epidural steroid injection (64483, 77003, 72100, 99144). The patient's date of injury is listed as xx/xx/xx. The patient is reported to have chronic back pain. A lumbar spine MRI performed on 9/15/10 noted L5-S1 disc bulge and facet arthropathy and moderate facet arthropathy at L4-5 with no neural compromise. On 6/23/11 the provider noted the patient's chief complaint was low back pain. The provider indicated the patient's pain was somewhat more severe with an increased need for pain medications. The severity of pain was noted as 9 out of 10 and the patient reported the frequency of her pain as "24/7." She has been taking OxyContin, Ambien and promethazine on a regular basis. The patient's physician noted that straight leg raising was asymptomatic bilaterally. The submitted documentation indicates transforaminal epidural steroid injections were administered at L5 in January 2011 and April 2011. Another transforaminal epidural steroid injection at L5 has been recommended at this time. The URA has denied this request indicating that the requested service is not medically necessary.

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

Review of the submitted clinical evidence does not demonstrate that this patient meets Official Disability Guidelines (ODG) criteria for lumbar epidural steroid injections. ODG guidelines concerning the use of epidural steroid injections for chronic low back pain allow for the use of this therapy for relief of chronic low back pain. However, there is a need for documentation of the response to prior injections with at least a 50% improvement of leg and/or back pain. The medical records submitted in this case do not indicate the response this patient had to either of the first two epidural steroid injections. In the absence of such evidence, the patient does not meet ODG criteria for another injection. All told, there is inadequate documentation that a third epidural steroid injection will be of any benefit and therefore it is not medically necessary.

### **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)