

MAXIMUS Federal Services, Inc.
11000 Olson Drive, Suite 200
Rancho Cordova, CA 95670
Tel: [800] 470-4075 Š Fax: [916] 364-8134

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: February 11, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ASC LESI L5-S1 (Lumbar Epidural Steroid Injection at L5-S1) 62311 under Fluoroscopy 77003 and MAC 01992.

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, ASC LESI L5-S1 (Lumbar Epidural Steroid Injection at L5-S1) 62311 under Fluoroscopy 77003 and MAC 01992, is not medically necessary for treatment of the patient's back pain.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

A xx-year-old female patient sustained an injury when she slipped and fell. In 2010, the patient presented with complaints of back pain, pins and needles, aching, burning and left shoulder pain. The patient has been assessed with back pain, lumbar, long-term (current) use of other medications; back pain, not otherwise specified; radicular pain; and pain in joint, shoulder region. The patient was referred to a pain management specialist after obtaining a left shoulder and lumbar MRI. The patient's provider states that while the patient's MRI does not show compression of a nerve, it is suggestive of an annular tear. According to the provider, nucleus pulposus can cause chemical radiculopathy. In addition, the provider states the patient had a positive straight leg raise test on the right, change in her neurological exam and complaints of radicular pain, particularly affecting her right leg.

The provider has requested authorization for the following service: ASC LESI L5-S1 (Lumbar Epidural Steroid Injection at L5-S1) 62311 under Fluoroscopy 77003 and MAC 01992. The Utilization Review Agent (URA) indicates the requested service is not medically necessary. According to the URA, the requested service is not within Official Disability Guidelines (ODG) as the patient's MRI of 4/13/10 does not corroborate radiculopathy. In addition, the URA states the medical records show the patient had one chiropractic visit on 4/15/10 and was referred to a pain management physician for further treatment. The URA further indicates the patient did not receive treatment from 2001 until 2010.

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

Upon review of the submitted clinical documentation, I find the requested service is not medically necessary. This patient was diagnosed with lumbar pain and left shoulder pain as the result of an initial injury. Based on the evidence provided, she last received treatment for this injury in 2001. The provider has proposed Epidural Steroid Injection for an injury which occurred in xxxx with a lapse in medical care for almost nine years. Under these circumstances, there is little likelihood that the patient had no intervening injury since the original accident. Nor do the records provided support an intervening aggravation of the initial injury. Furthermore, the ODG recommends conservative treatment for 2 -6 weeks before recommending Epidural Steroid Injection; the records provided do not document recent conservative treatment.

Given these findings, the requested service, ASC LESI L5-S1 (Lumbar Epidural Steroid Injection at L5-S1) 62311 under Fluoroscopy 77003 and MAC 01992, is not medically necessary for this patient.

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)