**MAXIMUS Federal Services, Inc.**
**11000 Olson Drive, Suite 200**
**Rancho Cordova, CA 95670**
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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**: July 1, 2011

**IRO CASE #:**

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

Lumbar epidural steroid injection at L5-S1 using fluoroscopy (62311, 77003, J3301, Q9967).

**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)

**[X] Overturned (Disagree)**

[ ] Partially Overturned (Agree in part/Disagree in part)

The requested lumbar epidural steroid injection at L5-S1 using fluoroscopy (62311, 77003, J3301, Q9967) 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 6/13/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 6/14/11.
3. Notice of Assignment of Independent Review Organization dated 6/14/11.
4. Request for Lumbar Epidural Steroid Injection from, MD dated 6/7/11.
5. Reconsideration Request for Lumbar Epidural Steroid Injection from MD dated 6/7/11.
6. Progress Note from Rio Grande Pain Team dated 5/17/11.
7. Radiology Report dated 2/9/10.
8. Report from MD dated 4/29/10.
9. Decision and Order
10. Denial Documentation.

## PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an on-the-job back injury on xx/xx/xx. An MRI performed on 2/9/10 revealed multiple level degenerative changes with bilateral facet synovitis at L4-5 and spondylolisthesis at L5-S1 with 3 mm central disc herniation with encasement of neural exit foramina. The patient's provider indicates the patient has completed a course of physical therapy and has been placed on pain medications. The provider further states that these conservative treatments have been unsuccessful in relieving the patient's pain. The provider has recommended a lumbar epidural steroid injection at L5-S1 with fluoroscopy.

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

Review of the submitted documentation indicates that the patient meets Official Disability Guidelines (ODG) recommendations for lumbar epidural steroid injection at L5-S1 using fluoroscopy. According to ODG criteria, epidural steroid injection can offer short-term pain relief and should be used in conjunction with other rehabilitation efforts, including continuing a home exercise program. In this patient's case, the physician notes document that physical exam and MRI were consistent with radiculopathy. The patient has been unresponsive to conservative treatment including a complete course of physical therapy as well as pain and anti-inflammatory medications. Thus, the patient is an appropriate candidate for the requested treatment. Epidural steroid injections are frequently used in the orthopedic community to help patients with back pain after a failure of conservative care. The use of epidural steroid injection in this setting is consistent with ODG criteria and is within the standard of care within the medical community.

For the reasons stated above, I have determined that the requested lumbar epidural steroid injection at L5-S1 using fluoroscopy (62311, 77003, J3301, Q9967) is medically necessary for treatment of the patient's medical condition.

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**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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)