

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

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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:** June 4, 2011

**IRO CASE #:**

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

Caudal lumbar epidural steroid injection #2.

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

M.D., Board Certified in Neurology.

**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 caudal lumbar epidural steroid injection #2 is not 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 5/12/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 5/13/11.
3. Notice of Assignment of Independent Review Organization dated 5/16/11.
4. Office Visit Notes from P.A., dated 3/23/11, 4/6/11, 4/14/11 and 4/27/11.
5. Lumbar MRI Report dated 2/14/11.
6. Status Report: Follow-Up Evaluation from MD dated 3/14/11.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

A patient sustained an on-the-job lifting injury on xx/xx/xx. An evaluation dated 3/14/11 indicated a pain level of 3 out of 10. The patient has been prescribed Skelaxin and ibuprofen. The provider indicates the patient participated in physical therapy. On 3/23/11, the patient indicated a pain level of 0-3 out of 10 at best and up to 7-9 out of 10 at worst. The provider noted shooting pains moving into the right lower extremity. Straight-leg raising was positive on the right. An MRI scan of the lumbar spine showed disc herniations at the L4-L5 and L5-S1 levels with mild encroachment of the neural foramina bilaterally at both levels. A lumbar epidural steroid injection was recommended at L5-S1. The records indicate the patient received an epidural steroid injection at L5-S1 on 4/6/11. On 4/27/11, the provider indicated the patient's pain was cut in half by the epidural steroid injection. The provider has requested a caudal lumbar epidural steroid injection #2 at L5-S1. The Carrier has denied this request indicating that the requested injection is not medically necessary for treatment of the patient's back pain.

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

Based on Official Disability Guidelines (ODG), the patient does not meet medical necessity for a second epidural steroid injection. Per ODG criteria, the patient does have symptoms and signs of radiculopathy. Further, the treatment notes indicate the patient's pain level was reduced by 50% following the first lumbar epidural steroid injection. However, the information provided shows only a three-week interval between the initial epidural steroid injection and the patient's follow-up visit on 4/27/11, at which time the second epidural steroid injection was recommended. According to ODG criteria, the patient must achieve 50% or greater pain reduction for a period of six to eight weeks following the initial injection as an indication for a second epidural steroid injection. Therefore, I find the requested service is not medically necessary for this patient's condition.

**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)