

**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 15, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal lumbar epidural steroid injection, L3-4 and L4-5 x 1 (64483 Inj Foramen Epidural L/S; 64484 Inj Foramen Epidural Add; 76005 Fluoroguide for Spine Inj; 72100 X-ray Exam of Lower Spine).

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, transforaminal lumbar epidural steroid injection, L3-4 and L4-5 x 1, (64483 Inj Foramen Epidural L/S; 64484 Inj Foramen Epidural Add; 76005 Fluoroguide for Spine Inj; 72100 X-ray Exam of Lower Spine), 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 10/24/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10/27/11.
3. Notice of Assignment of Independent Review Organization dated 10/27/11.
4. Progress notes from MD dated 8/1/11, 4/25/11, 2/21/11, 12/20/10, and 11/22/10.
5. Operative Report from Surgery Center dated 12/10/10.
6. MRI of the Lumbar Spine without Contrast dated 12/10/09.
7. Denial documentation dated 9/9/11 and 8/10/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The records document that this patient is a male who presents with complaints of pain to his bilateral lower extremities, somewhat into the knee on the left secondary to a work injury on xx/xx/xx. There are no other reported symptoms of dyesthesias or weakness. A magnetic resonance imaging (MRI) from 2009 documented moderate narrowing of the left neural foramen and severe narrowing of the right neural foramen at the levels of L4-5 and L5-S1, as well as disc bulging at those levels. The MRI also revealed facet arthropathy at the levels of L3-S1. Examination findings have included some pain with straight leg raise test, pain with femoral stretch, decreased sensation in the anterior thigh, and hypoactive reflexes on the right. The patient underwent epidural steroid injection (ESI) at L3-4 and L4-5 in December 2010 and was evaluated 10 days later. However, there was no reference as to the patient's response to injections in the records provided for review. At the February 2011 visit, the patient reported that injections had been helpful and the provider recommended additional ESI treatment at L3-4 and L4-5.

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

The purpose of epidural steroid injection (ESI) is to reduce pain and inflammation, facilitating progress in more active treatment programs, reduction of medication use, and avoiding surgery. However, this treatment alone offers no significant long-term functional benefit. The ODG state that, "At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of

multilevel pathology.” In addition, there should be an interval of at least one to two weeks between injections. Overall, repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. In the therapeutic phase, indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year (Boswell, et al).

Consistent with the ODG recommendations, the patient’s request for ESI at L3-4 and L4-5 cannot be recommended as medically necessary. The patient’s records do not clearly delineate any radicular symptoms or consistent radicular findings on exam. Further, there is no documentation of any functional improvement with the injections that were previously given. Moreover, the patient’s MRI does not reveal any neural compressive lesion at L3-4. According to ODG, objective findings on examination need to be present and radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. These criteria for the use of ESI have not been established in the patient’s case. Therefore, the requested service is not medically necessary.

I have determined the requested service, transforaminal lumbar epidural steroid injection, L3-4 and L4-5, (64483 Inj Foramen Epidural L/S; 64484 Inj Foramen Epidural Add; 76005 Fluoroguide for Spine Inj; 72100 X-ray Exam of Lower Spine), is not medically necessary for treatment of the patient’s medical 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)

1. Boswell, M., et al. A systematic review of therapeutic facet joint injections in chronic spinal pain. *Pain Physician*, 2007 Jan;10(1):229-53.

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)