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**Notice of Independent Review Decision
Reviewer's Report**

DATE OF REVIEW: October 5, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral transforaminal epidural steroid injection at L5-S1.

**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)
- Overtured (Disagree)**
- Partially Overtured (Agree in part/Disagree in part)

The requested bilateral transforaminal epidural steroid injection at L5-S1 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 9/14/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 9/14/11.
3. Notice of Assignment of Independent Review Organization dated 9/15/11.
4. Medical records from MD dated 8/3/11, 6/23/11, 5/18/11, and 5/9/11.
5. Medical records from MD dated 8/16/11.
6. Medical records from Physical Therapy dated 6/6/11.
7. Nerve conduction studies dated 5/18/11.
8. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

A review of the record indicates the patient is a male who sustained a work-related injury on xx/xx/xxxx while moving a pallet. The patient experienced onset of low back pain and lower extremity pain. He is status post L5-S1 laminectomy and discectomy in 2008. The patient states the pain initially radiates down the right leg, but then goes on to the left lower extremity from the sacroiliac joint region to the bottom of his foot. The patient has no bowel or bladder incontinence or gait ataxia. The patient reports that his toes go numb and he has some secondary weakness. An MRI scan performed on 3/28/11 showed a mild loss of disc space and a 5mm paracentral disc herniation at L5-S1. The patient underwent an epidural steroid injection on 7/22/11. The patient's provider noted the patient was 30-40% improved. A request has been made for bilateral transforaminal epidural steroid injection at L5-S1. The URA indicates the patient does not meet Official Disability Guideline (ODG) criteria for epidural steroid injection. The URA states the patient did not demonstrate 50% pain relief with prior injections.

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

Upon review of the submitted documentation, I have determined that bilateral transforaminal epidural steroid injection at L5-S1 is medically necessary for this patient. The submitted documentation demonstrates the patient experienced up to 40% improvement in pain levels with his first injection. While ODG criteria make reference to a 50% pain reduction, these guidelines also note that the purpose of epidural steroid injection is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use, and avoidance of surgery. Since this patient did experience significant reduction of pain with the prior epidural steroid injection, the guidelines allow for sufficient latitude to permit a second set of injections to be performed in this case. Repeat epidural steroid injection in this situation is consistent with accepted medical standards for management of patients with low back pain with radiculopathy. Thus, continued treatment with epidural steroid injection is medically indicated and 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)