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Amended October 21, 2011

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: October 18, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar transforaminal epidural steroid injection L5-S1 (64483, 77003).

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, outpatient lumbar transforaminal epidural steroid injection L5-S1 (64483, 77003), 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 9/23/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 9/27/11.
3. Notice of Assignment of Independent Review Organization dated 9/28/11.
4. Medical records from Back Institute dated 10/7/09, 10/8/09, 4/9/10, 9/10/10, 12/20/10, 12/20/10, 3/15/11, 7/18/11, and 8/16/11.

5. List of Prescriptions.
6. CT lumbar spine dated 7/18/11.
7. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work injury on xx/xx/xx. The patient complains of bilateral lower extremity pain. The medical records indicate the patient is status post lumbar spine surgery in 2004 and had a spinal cord stimulator inserted for chronic pain. The patient has been assessed with chronic, intractable back and leg pain secondary to work-related injury with failed back surgery syndrome and increasing leg pain. The patient's provider recommended a CT myelogram of the lumbar spine on 12/20/10 for increased pain and increased difficulty to perform activities of daily living (ADLs). Her spinal cord stimulator was adjusted. On follow-up on 3/15/11, the patient continued to need Klonopin 1 mg twice daily, Norco 10/325 two tablets three times daily, Flexeril 10 mg three times a day, and Lunesta 3 mg to allow her to perform her ADLs. On 7/18/11, a lumbar CT scan was performed noting the presence of dorsal stimulator wires, L4-5 broad based posterior disc protrusion with marked left and mild right foraminal narrowing, severe degenerative disc disease at L5-S1 with severe right bony foraminal narrowing and mild left foraminal narrowing, and L3-4 and L4-5 spinal stenosis suggested but not well visualized. The patient's physician requested outpatient lumbar transforaminal epidural steroid injection L5-S1 (64483, 77003). The URA indicates the patient does not meet criteria for epidural steroid injection.

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

The Official Disability Guidelines (ODG) for epidural steroid injection for low back and leg pain requires evidence of radiculopathy by clinical, x-ray or electrodiagnostic findings. This patient's 7/18/11 lumbar CT scan identified neuroforaminal narrowing ranging from mild to severe. The URA indicates there is a lack of proof from physical exam of the presence of radiculopathy; however, the physical exam performed in December 2010 did identify radiculopathy. The 7/18/11 lumbar CT scan corroborated the physical findings. Since this patient has had pain dating back to 2003, she qualifies as a chronic pain patient (pain greater than six months) and the ODG does support lumbar epidural steroid injection as medically necessary for low back pain, particularly since the patient's recent treatment has not been effective.

Therefore, I have determined that outpatient lumbar transforaminal epidural steroid injection L5-S1 (64483, 77003) is 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)

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