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Notice of Independent Review Decision

DATE OF REVIEW: December 6, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L2-3 intralaminar steroid injection #3 (62311 and 99144).

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)

I have determined that the requested services are not medically necessary for the 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 11/13/13.

2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/15/13.
3. Notice of Assignment of Independent Review Organization dated 11/18/13.
4. Denial documentation.
5. Pre-authorization request forms dated 9/09/13 and 10/03/13.
6. Medical records from Pain Center dated 6/04/13, 9/09/13 and 10/02/13.
7. Magnetic resonance imaging of lumbar spine dated 11/22/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury on xx/xx/xx. On 6/04/13, the records noted that the patient was status post lumbar steroid injection. She reported 50% relief following the injection, with return of symptoms. On 10/02/13, physical examination revealed positive straight leg raising on the left with gluteal tenderness and paravertebral muscle spasm. Additionally, decreased sensation to bilateral L2 dermatomes was noted. The patient was diagnosed with lumbosacral or thoracic radiculopathy. The treatment plan included repeat interlaminar L2-3 steroid injection. Coverage for L2-3 intralaminar steroid injection #3 (62311 and 99144) has been requested.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial stated that the magnetic resonance imaging (MRI) report is illegible. Per the URA, if the patient is not improved, she should be evaluated by a neurological surgeon. On appeal, the URA noted that the necessity for a repeat interlaminar epidural steroid injection is not validated by the patient's medical records.

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

Per Official Disability Guidelines, epidural steroid injections are a possible option for short-term treatment of radicular pain when used in conjunction with active rehabilitation efforts. Radiculopathy must be documented by objective findings on examination and corroborated by imaging studies and/or electrodiagnostic testing. Additionally, patients should also be initially unresponsive to conservative treatment. Repeat injections are based on continued objective documented pain relief, decreased need for pain medications, and functional response. If after the initial block or blocks are given and found to produce 50% to 70% pain relief for at least 6 to 8 weeks, additional blocks may be supported. The most recent physical examination revealed tenderness to palpation, muscle spasms, and right-sided positive straight leg raising. There is no evidence of imaging studies or electrodiagnostic studies provided to corroborate a diagnosis of radiculopathy. Further, there is no evidence of a failure to respond to conservative treatment including exercises, physical methods, nonsteroidal anti-inflammatory medications, and muscle relaxants. All told, L2-3 intralaminar steroid injection #3 (62311 and 99144) is not medically indicated for the treatment of this patient.

Therefore, I have determined the requested services are 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 JUDGMENT, 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)