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Notice of Independent Review Decision

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: April 15, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar transforaminal epidural steroid injection (ESI) bilateral L5 and S1 with monitored anesthesia and two week post injection follow-up visit.

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

M.D., Board Certified in Anesthesiology and Pain Medicine.

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 lumbar transforaminal epidural steroid injection (ESI) bilateral L5 and S1 with monitored anesthesia and two week post injection follow-up visit 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 3/25/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 3/27/13.

3. Notice of Assignment of Independent Review Organization dated 3/27/13.
4. Denial documentation dated 2/27/13 and 3/20/13.
5. Pre-certification Request dated 2/22/13.
6. MRI Lumbar Spine dated 6/1/12.
7. Clinic notes dated 2/21/13 and 3/12/13.
8. Clinic notes dated 7/11/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work related injury to his thoracic/lumber as a result of a fall on xx/xx/xx. The MRI of the lumbar spine on 6/1/12 showed a moderate desiccation and mild narrowing of the intervertebral disc at the L5-S1 level. The MRI also evidenced broad based posterocentral 6mm disc herniation indents the anterior thecal sac and mild facet hypertrophy and neural foramina were patent. The patient complains of low back and bilateral lower extremity pain. The provider reported the patient rates his pain at 5/10 to 6/10 and upon physical exam of the patient a pin prick sensation was decreased in the bilateral L5-S1 dermatomes. The patient's motor testing showed well developed and symmetrical musculature in the bilateral lower extremities. There is no documented evidence of any weakness at L5 through S1. The provider reported that the patient continues to report moderate complaints of pain greater than two weeks from recurrent radicular symptoms despite a greater than 50% overall improvement from the initial positive response to the first transforaminal injection. The medical records indicate past conservative measures failed to control the patient's symptomatology. The provider recommended repeat transforaminal injection.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA's initial denial stated that documentation from examinations performed in 2012 and 2013 indicate a normal lower extremity neurological examination and there appears to be lack of any lower extremity neurological deficits. On 3/20/13, the URA reported that the request was again non-certified as the patient is healthy, without psychological overlay and of normal body size, thus the requested service is not required.

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

In this patient's case, Official Disability Guidelines (ODG) do not support the requested lumbar transforaminal epidural steroid injection (ESI) bilateral L5 and S1 with monitored anesthesia and two week post injection follow-up visit. The submitted documentation indicates the patient presents with moderate complaints of pain to his lumbar spine with radiation down his bilateral lower extremities. The provider reported the patient continued to suffer for greater than two weeks from recurrent radicular symptoms despite greater than 50% overall improvement from the initial positive response to the first transforaminal injection. The specific date of service for the patient's initial transforaminal epidural steroid injection is not documented in the medical records provided. Additionally, there is a lack of documentation of objective functional improvements, decrease in rate of pain on the visual analog scale (VAS) and decrease in his medication regimen to support repeat blocks. Per ODG criteria, repeat injections should be based on continued objective documented pain relief, decreased need for pain medications and

functional response. Finally, the provider is requesting the patient undergo monitored anesthesia during the procedure, this is not generally standard of care as response to the anesthesia may negate the patient's response to the pain relief of the transforaminal epidural steroid injection. The submitted documentation indicates that the patient does not present with any psychological overlay or diagnoses or history of anxiety. All told, the requested lumbar transforaminal (ESI) bilateral L5 and S1 with monitored anesthesia and two week post injection follow-up visit is not consistent with ODG criteria and therefore is not supported as medically necessary.

In conclusion, I have determined the requested lumbar transforaminal epidural steroid injection (ESI) bilateral L5 and S1 with monitored anesthesia and two week post injection follow-up visit 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 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)