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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: July 26, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar left L4 transforaminal epidural steroid injection.

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 outpatient lumbar left L4 transforaminal epidural steroid injection 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 6/19/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/3/13.
3. Notice of Assignment of Independent Review Organization dated 7/8/13.
4. Denial documentation dated 5/22/13, 6/11/13 and 7/3/13.
5. MRI Lumbar Spine dated 6/22/12.
6. Clinic notes dated 7/10/12, 7/13/12, 7/30/12, 8/28/12, 9/7/12, 9/21/12, 4/15/13, 4/22/13, 5/15/13, 6/4/13 and 6/26/13.

7. Clinic notes dated 5/1/13.
8. Clinic note dated 4/15/13.
9. Physical Therapy Evaluation and Plan of Care dated 9/12/12, 4/24/13 and 6/13/13.
10. Physical Therapy Evaluation and progress notes dated 9/12/12, 9/14/12, 9/18/12, 9/20/12, 10/23/12, 4/24/13, 4/29/13, 5/9/13 and 5/13/13.
11. Physical Therapy Evaluation and Letter of Medical Necessity dated 9/12/12, 10/23/12 and 4/24/13.
12. Surgery Center Operative Note dated 7/13/12 and 9/7/12.
13. Pre-authorization denial for Lumbar/Sacral ESI level left L4 and L5 dated 5/17/13.
14. Pre-authorization denial for Lumbar ESI, left L4 dated 6/10/13 and 7/3/13.
15. Pre-authorization denial for Lumbar/Sacral ESI, left L4 dated 6/28/13.
16. Pre-authorization approval for Physical Therapy dated 4/15/13.
17. Pre-authorization approval for Lumbar Transforaminal ESI, bilateral L4 dated 4/22/13.
18. Pre-authorization approval for Lumbar/Sacral ESI level left L4 and L5 dated 7/10/12 and 8/29/12.
19. Substantial Change Assessment dated 6/28/13.
20. Orders for CPT 64483 Lumbar/Sacral (ESI) Transforaminal Injection dated 5/15/13, 6/4/13 and 6/26/13.
21. Appeal/Reconsideration Acknowledgement Letter dated 6/10/13.
22. Prospective IRO Review Response dated 7/10/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work related injury on xx/xx/xx after twisting and feeling a pull and later feeling a sharp spasm. An MRI of lumbar spine dated 6/22/12 revealed a small 1mm laterlizing disc bulge at L1-2 and L2-3 with widely patent neural foramina and mild facet degenerative changes at these two levels, at L3-4 a 3mm central disc protrusion was noted to contain a small central annular tear, no herniation or spinal stenosis and the neural foramina was noted to be patent. At an office visit on 7/10/12 the patient reported pain at 3/10 and was noted to have two sessions of physical therapy, but he was unable to continue with additional sessions due to pain. Upon physical examination the provider noted the patient's gait to be antalgic, muscle strength at 5/5 and lumbar range of motion to be restricted. The patient was recommended for a left L4 and L5 transforaminal epidural steroid injection (ESI). On 7/13/12 the patient had a left L4 and L5 transforaminal ESI with no complications. On 7/30/12 the patient reported pain at 1/10 and reported pain to have improved from 60% on left and 10% on the right in his low back with radicular pain in his hips and legs. The patient reported a 60% improvement in pain after the previously performed injection. The patient was also noted to continue to have pain which appeared to be worse on the right in the same pattern. The provider recommended additional therapy sessions. On 9/21/12 the patient reported pain at 0/10 with 75% improvement with injection and physical therapy. The patient requested work restrictions removed and the patient agreed to continue an additional 4 to 6 therapy sessions. On 4/15/13 the patient reported pain at 9/10 and stopped taking gabapentin due to having no effect on his pain. The provider noted that the patient was dependent on a walker for ambulation and his muscle strength was 5/5. The provider also noted the patient's range of motion of the lumbar spine to be limited secondary to pain with significant muscular shift to the left. The patient was recommended for an additional 4 sessions of physical therapy to include modalities such as ice, heat, ultrasound and

transcutaneous electrical nerve stimulation (TENS) for acute flare of pain. The patient was given an oral steroid to taper for an acute flare up of pain as well as Valium for muscle spasms and hydrocodone for increased pain. The patient was taken off work duties until re-evaluation. On 4/22/13, the patient reported pain at 6/10 and was noted to have acute muscle spasm. The patient was recommended for ESI. On 5/1/13 the patient had bilateral L4 transforaminal ESI without complications. On 5/15/13 the patient reported almost complete pain relief of 3 to 4 days with some symptoms returning. The patient also reported persistent low back pain radiating down his left leg and reported 70% pain relief over the baseline as compared to an office visit a few weeks earlier. On 6/4/13 the patient reported pain at 4/10 and on 6/26/13 the patient reported pain at 3/10. Left L4 transforaminal epidural steroid injection has been recommended.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA's denial stated that ODG guidelines do not support the lumbar epidural steroid injection, left L4 as repeat ESI injections would only be supported if there is 50-70% improvement in symptoms for six to eight weeks time and the records do not reflect how long the patient had benefit from the last injection. The URA further stated that most recent physical examination findings have not documented any significant physical examination findings of a lumbar radiculopathy.

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 epidural steroid injection (ESI), L4. Per ODG criteria, repeat injections should be based on continued objective documented pain relief, decreased need for pain medications and functional response. Guidelines recommend pain relief of at least 50-70% improvement for at least six to eight weeks as indication for repeat blocks. The submitted documentation indicates the patient reported pain to be at 6/10 prior to the most recently performed epidural injection, with a return of pain within two weeks to 3/10. On 6/4/13 the pain was noted to have increased to 4/10. The submitted documentation indicates that the patient is taking Norco 7.25/325mg 1 by mouth up to four times per day as needed for the pain. However, the documentation submitted does not indicate that the patient had a reduced need for pain medication. Additionally, the documentation submitted for review does not indicate the patient had a positive functional response as quantitative measurements or return to work status were not provided in the clinical records following the most recent ESI. Based on the documentation submitted for review, continued objective documented pain relief, decreased need for pain medication and functional response were not identified. All told, the requested lumbar epidural steroid injection, L4 is not consistent with ODG criteria and therefore is not supported as medically necessary.

Therefore, I have determined the requested outpatient lumbar left L4 transforaminal epidural steroid injection 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)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)