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**Notice of Independent Review Decision**

**DATE OF REVIEW:** August 2, 2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Caudal ESI (62311 and 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 and Pain Management.

**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 Caudal ESI (62311 and 77003) is not medically necessary for the treatment of the patient's medical condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Requests for a Review by an Independent Review Organization dated 7/11/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) 7/12/13.
3. Notice of Case Assignment dated 7/15/13.
4. medical records review.
5. Pre-Authorization request form dated 5/31/13 through 6/30/13.
6. Minimally Spine Institute clinic notes dated 6/26/13, 5/20/13, and 5/1/13.
7. Neuroradiology MR scan of the lumbar spine dated 5/8/13.
8. medical records review.
9. Letter dated 6/10/13.

10. Denial documentation dated 7/16/13, 7/12/13, 6/10/13, and 5/31/13.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female with complaints of back pain. On 5/1/13, she was seen in clinic with evaluation. At that time, she reported 75% back pain and 25% leg pain. She stated these symptoms occurred after she had been pushed to the floor while separating a fight at work. Upon examination, she had a normal heel strike and toe-off gait pattern. She could heel walk and toe walk without difficulty. There was tenderness to palpation to the midline of the lumbar spine to L5-S1 and she had full range of motion. Neurologically, there was a mildly positive straight leg raise on the left and negative on the right. Deep tendon reflexes were 2+ in the patellar and Achilles bilaterally. She did have depressed sensation to light touch in the left lateral shin, foot, and dorsal foot with otherwise intact sensation. She had 4/5 plantar flexion strength on the left during toe raise, compared to 5/5 on the right, and she had 4/5 left gastrosoleus strength compared to 5/5 on the right. All muscle groups tested were 5/5. X-rays showed decreased disc space at the L4-5 and L5-S1 levels. The provider's assessment was lumbar sprain/strain. The provider recommended a magnetic resonance imaging (MRI) of the lumbar spine.

On 5/8/13, an MRI of the lumbar spine revealed mild upper lumbar scoliosis convex to the right with midline disc protrusion at L5-S1 and mild encroachment on the thecal sac. There was a left paracentral disc protrusion at L4-5 with minor narrowing of the left lateral recess. Degenerative disc disease and disc desiccation were seen at L4-5 and L5-S1 with mild multilevel degenerative changes in the facet joints. On 5/20/13, the patient returned to the clinic for further evaluation. She continued to have mild weakness rated at 4+/5 on the left gastrosoleus as compared to the right and all muscle groups tested were 5/5. She had a mildly positive straight leg raise on the left and negative on the right. She had paresthesias to the left lateral shin, but otherwise, sensation was intact. A caudal epidural steroid injection (ESI) was recommended at that time.

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

The medical records submitted for this review indicate that this patient complained of 75% back pain and 25% leg pain on 5/1/13. At that time, she did have slightly decreased strength in the plantar flexion on the left compared to the right and had decreased sensation to the left lateral shin, foot, and dorsal foot. The MRI revealed degenerative disc disease with a small midline disc protrusion at L5-S1 mildly encroaching on the thecal sac and at L4-5 there is also minor disc desiccation as well as minor degenerative disc disease, and a left-sided disc protrusion with minor narrowing of the left lateral recess. Her last clinical exam did not specifically detail the lumbar spine. Although the 5/1/13 note does indicate that previous treatments included anti-inflammatory medications and muscle relaxants, these are not objectively documented as to the specific medications, duration, and the efficacy of the medications. Physical therapy notes were not provided for review.

The Official Disability Guidelines (ODG) state that radiculopathy must be documented with objective findings on examination to be present and corroborated by imaging studies and/or electrodiagnostic studies. Further, the patient should be initially unresponsive to conservative measures such as exercises, physical methods, NSAIDs, and muscle relaxants. This patient has documentation of radiculopathy in the left lower extremity as evidenced by the 5/20/13 clinic note. This indicates she has mild weakness rated at 4+/5 in the left gastrocnemius compared to 5/5 on the right. She also had paresthesias to the left lateral shin. Although the MRI reveals a small disc herniation at L4-5 on the left, there is only mild narrowing of the left lateral recess per that exam. In addition, the clinical notes submitted for review do not include details on conservative measures, durations, and outcomes. Overall, there is lack of significant radiculopathy on MRI study to correlate with the physical exam and there is lack of documentation of failure of conservative measures.

Therefore, I have determined the requested Caudal ESI (62311 and 77003) 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)