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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: FEBRUARY 15, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Selective nerve root injection at the left L5-S1 under epidurography.

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)

The requested service, selective nerve root injection at the left L5-S1 under epidurography, 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 1/24/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 1/25/13.
3. Notice of Assignment of Independent Review Organization dated 1/28/13.
4. Scripts for Orders dated 1/7/13.
5. Patient Profile dated 7/17/12.
6. Office Visit notes dated 1/4/13.

7. operative report dated 11/20/12, 11/15/11, and 3/29/11.
8. radiology report dated 11/20/12 and 4/11/11.
9. behavioral medicine evaluation dated 8/20/12.
10. follow-up dated 7/16/12, 4/16/12, 3/12/12, 2/6/12, 12/1/11, 10/4/11, 6/21/11, 4/22/11, 3/29/11, 2/2/10, 1/27/10, 12/21/09, 11/9/09, 10/19/09, 9/21/09, and 8/25/09.
11. operative report dated 8/8/11.
12. HIS radiology report dated 6/10/11.
13. Peer Review dated 5/23/11.
14. physical therapy daily note dated 5/20/11, 5/19/11, 5/17/11, 5/10/11, and 5/3/11.
15. Initial/Continued Plan of Care.
16. ODG Guidelines.
17. on-call report dated 3/29/11.
18. periodic outcomes evaluation dated 3/29/11.
19. cope program evaluation dated 11/19/09.
20. radiology report dated 11/9/09 and 9/21/09.
21. therapy progress note dated 9/30/09 and 9/8/09.
22. radiology report dated 8/25/09.
23. Lumbar post-op physical therapy evaluation dated 7/30/09.
24. radiology report dated 7/8/09, 7/7/09, 5/12/09, and 4/30/09.
25. operative report dated 7/7/09.
26. consultation dated 5/12/09 and 4/30/09.
27. Denial documentation dated 1/22/13 and 1/10/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury on xx/xx/xx. The patient was seen on 4/30/09 with complaints of low back and bilateral leg pain. The patient had a history of three epidural steroid injections (ESI) and physical therapy. On examination, the patient had 4/5 right anterior tibialis and extensor hallucis longus strength with paresthesias in the right L5 distribution. Magnetic resonance imaging (MRI) of the lumbar spine on 5/12/09 revealed findings of 5 to 6 mm broad based posterior disc extrusion at L5-S1, slightly impressing upon the anterior aspect of the thecal sac and effacing the left S1 nerve root without displacement. On 7/7/09, the patient underwent anterior interbody fusion, discectomy, and corpectomy at the L5-S1 level. The patient also underwent posterolateral fusion with placement of pedicle screws. Surgical intervention also included left sided laminotomy and discectomy at L2-3. Clinical notes dated 3/29/11 reported the patient complained of 5/10 pain. The patient was noted to have no neurological deficits on examination, but was complaining of pain radiating to the buttocks and posterior calf. The patient also had some numbness in the posterior calf. The patient has requested authorization and coverage for selective nerve root injection at the left L5-S1 under epidurography, which has been denied as not medically necessary.

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

The request for selective nerve root injection at the left L5-S1 under epidurography is not medically necessary for treatment of this patient's medical condition. The request has been

denied by the Carrier due to lack of evidence of radiculopathy on physical examination and imaging. The documentation submitted for review did not address any concerns of the prior denials. There is a lack of any recent comprehensive physical examination and/or imaging studies that reveal evidence consistent with lumbar radiculopathy to support an indication for left sided L5-S1 selective nerve root block. As such, the requested procedure is not supported by ODG guidelines as medically necessary for evaluation and treatment of this patient's medical condition.

Therefore, I have determined the requested selective nerve root injection at the left L5-S1 under epidurography 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)