

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Review Decision

DATE OF REVIEW: October 20, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

OP left L4-5 transforaminal epidural steroid injection (ESI), 64483, 64484 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.

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 OP left L4-5 transforaminal epidural steroid injection (ESI), 64483, 64484 and 77003 is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with a chief complaint of low back pain that resulted from a fall on xx/xx/xx. The patient's diagnoses include back pain with radiation, displacement of thoracic/lumbar intervertebral disc without myelopathy, and lumbosacral spondylosis without myelopathy. His surgical history includes right L4-S1 laminectomy with discectomy. An electrodiagnostic study performed on 6/25/14 revealed findings consistent with acute bilateral L5 and S1 root irritation consistent with radiculopathy with some evidence of ongoing denervation. It was noted that the examination did not point towards a myopathic process and/or generalized neuropathy. Other therapies were noted to include physical therapy, medications, and epidural

steroid injections. On 6/25/14, the records noted that the patient presented for initial evaluation due to a chief complaint of low back and bilateral leg pain. The patient described the pain as starting in the low back and radiating to the hips bilaterally down into the lower extremities, the left worse than the right. The patient rated the pain 4/10. On physical examination, it was noted the patient had tenderness to palpation at the L4 spinous process. There was no evidence of facet tenderness and no pain with facet loading. Straight leg raise test was negative bilaterally. The records noted that range of motion of the spine was normal with noted pain during flexion. Motor strength was normal throughout the lower extremities. Deep tendon reflexes were equal and symmetrical throughout. It was also noted that sensation was intact to light touch in all extremities. A request has been submitted for OP left L4-5 transforaminal epidural steroid injection (ESI), 64483, 64484 and 77003.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial noted that although recent diagnostic evaluations had indicated positive findings, the current examination did not reflect objective neurologic deficits consistent with radiculopathy at the specified injection level. The URA noted that the patient exhibited normal strength, reflexes and sensation in the lower extremities with negative straight leg test. Per the URA, given the lack of objective clinical findings to support the requested services, the medical necessity is not substantiated. On appeal, the URA noted that while the patient reports low back pain, the records submitted for review did not contain specific objective findings such as sensorimotor deficits and positive provocative tests to support the diagnosis of left L4-5 radiculopathy.

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

According to the Official Disability Guidelines (ODG), epidural steroid injections may be recommended under certain criteria. These criteria include evidence of radiculopathy due to herniated nucleus pulposus, but not spinal stenosis with unequivocal objective findings on examination; radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing; patients are unresponsive to conservative treatment including exercise, physical methods, nonsteroidal anti-inflammatory drugs (NSAIDs) and muscle relaxants; and injections should be performed using fluoroscopy. In addition, the guidelines state that the purpose of epidural steroid injections is to reduce pain and inflammation, thereby facilitating progression to a more active treatment program, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. In this patient's case, there is a lack of unequivocal objective findings of radiculopathy during examination that would warrant the need for an epidural steroid injection. In addition, there is lack of evidence that the patient will be participating in an active treatment program in conjunction with this requested service, as the requested service does not provide significant long-term functional benefit on its own. Thus, the requested epidural steroid injection is not medically necessary in this patient's case.

Therefore, I have determined the requested OP left L4-5 transforaminal epidural steroid injection (ESI), 64483, 64484 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)