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Notice of Independent Review Decision

DATE OF REVIEW: January 16, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Second lumbar epidural steroid injection at left L4, L5, S1.

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 second lumbar epidural steroid injection at left L4, L5, S1 is not medically necessary for the 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 12/13/13.
2. Notice of Assignment of Independent Review Organization dated 12/30/13.
3. Denial documentation.
4. Procedure Orders dated 10/17/13.
5. Medical records dated 8/08/13 and 10/11/13.
6. Electrodiagnostic testing dated 1/22/13.
7. MRI of the lumbar spine dated 1/14/13.
8. Operative report dated 4/09/13.

9. Medical records dated 12/17/12, 12/21/12, 1/02/13, 1/03/13, 1/08/13, 1/10/13, 1/15/13, 1/17/13, 1/23/13, 1/25/13, 1/29/13, 2/05/13, 4/02/13, 4/10/13, 4/11/13, 4/15/13, 4/16/13, 4/18/13, 4/22/13, 7/07/13, 7/11/13, 8/14/13, 8/28/13, and 9/27/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male with a date of injury of xx/xx/xx. On 1/14/13, magnetic resonance imaging (MRI) of the lumbar spine revealed an annular tear at L4-5 with a left paracentral/foraminal disc herniation with resultant mild narrowing of the central canal. At L5-S1, there was a diffuse disc herniation with bilateral facet arthropathy, causing mild narrowing of the spinal canal and bilateral neural foraminal narrowing. On 1/22/13, electrodiagnostic study revealed findings consistent with a left mild acute L5 and S1 lumbar radiculopathy. On 4/09/13, left L4, L5, and S1 transforaminal epidural steroid injections with local anesthetic and steroids using fluoroscopy were performed. On 8/08/13, the patient reported he experienced approximately two months of pain relief after the epidural steroid injection. His pain was still rated at 7/10 at that time. Upon evaluation, strength testing in the bilateral lower extremities was 5/5 with the exception of 4/5 great toe dorsiflexion on the left. Patellar reflexes were rated at 2/4 on the right and 1/4 on the left, and Achilles reflexes were both rated at 2/4. Sensation was decreased in a left L5 and L4 distribution. On 10/11/13, the patient reported continued pain to his low back with numbness and tingling radiating into his left lower extremity. He stated he was currently not attending the physical therapy program and reported his medications helped reduce his pain. Strength testing in the bilateral lower extremities was rated at 5/5 with the exception of great toe dorsiflexion rated 4/5, patellar reflex on the right was 2/4 and on the left 1/4, and Achilles reflexes were 2/4 bilaterally. Sensation was decreased in the left L4 and L5 distributions. A request has been submitted for second lumbar epidural steroid injection at left L4, L5, S1.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial indicated that the patient underwent an initial epidural steroid injection on 4/09/13. Per the URA, there was no evidence of objective functional improvement or decreased need for pain medications as a result of the first procedure. On appeal, the URA noted that true objective functional improvement has not been established as a result of the initial injection.

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

Per ODG criteria, additional epidural steroid injections may be indicated if initial block produces pain relief of at least 50-70% pain relief for at least 6-8 weeks. Additionally, ODG criteria note that repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. In this patient's case, overall functional improvement from the epidural steroid injection was not documented. On 4/23/13, the patient's medications were refilled. The records do not document a reduction of medication to substantiate true functional improvement which would warrant a repeat injection. All told, the requested lumbar epidural steroid injection is not medically indicated in this patient's case.

Therefore, I have determined the requested second lumbar epidural steroid injection at left L4, L5, S1 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)