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Notice of Independent Review Decision

DATE OF REVIEW: December 20, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Caudal lumbar epidural steroid injection (CPT codes 62311 and 72275-26).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Physical Medicine & 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 caudal lumbar epidural steroid injection (CPT codes 62311 and 72275-26) 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 11/27/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/29/13.
3. Notice of Assignment of Independent Review Organization dated 12/02/13.
4. Denial documentation.
5. Authorization request dated 10/18/13.
6. Medical records dated 6/27/12, 11/12/12, 12/21/12, 1/28/13, 5/03/13, 5/06/13, 8/02/13, 10/14/13, and 10/18/13.
7. Procedure note from caudal epidural steroid injection dated 5/20/13.
8. Electrodiagnostic studies dated 5/11/12.

9. Notes from left L5 selective nerve root injection dated 6/01/12.
10. Operative report dated 3/14/08.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who presented to his provider on 10/14/13. The medical records noted an L5-S1 fusion in the past. The patient reported worsening pain and weakness, left leg greater than right leg. He had a caudal epidural steroid injection five months earlier which provided pain relief until prior to this most recent visit. There was no bowel or bladder dysfunction reported. The patient reported aching pain in the low back and both lower extremities. His medications included Ultram and Flexeril. Coverage for caudal lumbar epidural steroid injection (CPT codes 62311 and 72275-26) has been requested.

The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial stated that the documentation noted that a previous caudal epidural steroid injection provided good pain relief. However, the percentage of improvement was not documented. Additionally, the URA noted there were no examination findings that identified a neurologic deficit in deep tendon reflexes, motor or sensory that would indicate a recurrence of radiculopathy to support an epidural steroid injection. On appeal, the URA noted there is no documentation showing that the patient has radicular pain as confirmed by imaging studies and objective findings on physical examination.

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

Per ODG criteria, lumbar epidural steroid injections may be recommended as a possible option for short-term treatment of radicular pain when used in conjunction with active rehabilitation efforts. Per the guidelines, a chronic duration of symptoms greater than six months has been found to decrease success rates. In this patient's case, the documentation does not demonstrate that the services at issue will be of benefit. The medical records do not include adequate documentation of physical findings which would support the requested services. There is a lack of supporting documentation in terms of objective findings and attempts to use less invasive means to support proceeding with an additional caudal epidural steroid injection. There is a lack of details regarding the increased or decreased use of medication that would support the requested procedure. Thus, caudal lumbar epidural steroid injection (CPT codes 62311 and 72275-26) is not medically necessary for the treatment of this patient.

Therefore, I have determined the requested caudal lumbar epidural steroid injection (CPT codes 62311 and 72275-26) 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)