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Notice of Independent Review Decision

DATE OF REVIEW: July 17, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar caudal epidural L5-S1 with CPT code 62311.

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)
- Overtured (Disagree)**
- Partially Overtured (Agree in part/Disagree in part)

I have determined that the requested lumbar caudal epidural L5-S1 with CPT code 62311 is 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 6/09/14.
2. Notice of Assignment of Independent Review Organization dated 7/10/14.
3. Denial documentation
4. Medical records dated 5/15/12, 11/09/12, 5/03/13, 8/07/13, 9/03/13, 11/05/13, 2/04/14, and 5/06/14.
5. Periodic outcomes evaluation dated 11/09/12, 5/03/13, 8/07/13, 9/03/13, 11/05/13, 1/06/14, and 2/04/14.
6. Medical records dated 8/12/13.
7. Operative reports dated 5/04/12 and 7/31/13.
8. Magnetic resonance imaging (MRI) of the lumbar spine dated 12/12/11.

9. Impairment rating dated 10/09/06.
10. Scripts for Orders dated 5/06/14.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female with a history of low back pain. The current diagnoses include cervical spondylosis without myelopathy, post laminectomy syndrome in the lumbar region, lumbosacral neuritis or radiculitis, and low back pain. The patient has a surgical history of an L4-5 fusion in 2005. Previous conservative treatment has included physical therapy, intermittent injections, and medication management. The patient currently utilizes Soma 350 mg and Ultracet 37.5/325 mg. On 12/12/11, magnetic resonance imaging (MRI) of the lumbar spine indicated posterolateral disc protrusion and herniation at L5-S1 with compromise of the left lateral recess and impingement on the left L5 nerve root. On 5/06/14, the patient presented for a follow-up with complaints of 3/10 pain. Physical examination on 5/06/14 revealed tenderness across the lumbosacral spine, restricted range of motion of the lumbar spine, positive straight leg raising on the right, and hypoesthesia in the right L5-S1 dermatome. X-rays obtained on that date indicated negative findings for a fracture or hardware abnormality. Treatment recommendations at that time included continuation of the current medication regimen and a lumbar epidural steroid injection. A request has been submitted for lumbar caudal epidural L5-S1 with CPT code 62311.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial noted that the findings of radiculopathy were somewhat equivocal at the right L5-S1 with hypoesthesia noted and radiculopathy in an L5-S1 distribution. Per the URA, there was no indication of motor loss, and there was no imaging or electrodiagnostic testing per the guidelines. On appeal, the URA noted that there is no clear documentation showing that the patient does suffer from radicular pain as confirmed by imaging studies. Per the URA, the patient has undergone some physical therapy, but there is no documentation showing type or amount and what length of relief, if any, this provided.

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

According to the Official Disability Guidelines, epidural steroid injections are recommended as a possible option for short-term treatment of radicular pain to be used in conjunction with active rehabilitation efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Additionally, patients should prove initially unresponsive to conservative treatment including exercises, physical methods, nonsteroidal anti-inflammatory medications, and muscle relaxants. As per the documentation submitted, the patient's MRI of the lumbar spine on 12/12/11 does indicate a posterolateral disc protrusion at L5-S1 with compromise of the left lateral recess and impingement on the left S1 and left L5 nerve root. The patient reports persistent lower back pain with radicular symptoms. The patient's physical examination continues to reveal positive straight leg raising and hypoesthesia at the L5-S1 distribution. The patient was previously treated with physical therapy, intermittent injections, and medication management. Given the patient's positive examination findings, imaging findings, and exhaustion of conservative treatment, the requested caudal epidural steroid injection at L5-S1 is medically necessary.

Therefore, I have determined the requested lumbar caudal epidural L5-S1 with CPT code 62311 is 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)