

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: May 14, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right transforaminal ESI L5/S1, CPT codes 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 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)

I have determined that the requested right transforaminal ESI L5/S1, CPT codes 64483, 64484 and 77003 is not medically necessary for the treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male with a reported date of injury of xx/xx/xx. On, magnetic resonance imaging (MRI) of lumbar spine revealed disc degeneration at L5-S1 with a prominent bulge of the disc to the left side of the spinal canal without significant nerve compression or foraminal encroachment. The patient returned to clinic on 1/09/14, and the records noted low back and bilateral leg pain. On 1/09/14, physical examination showed decreased sensation on the right at

L5-S1, and the records noted a positive straight leg raise on the right. Per the submitted documentation, the patient has been prescribed Naprosyn as well cyclobenzaprine. A request has been submitted for right transforaminal ESI L5/S1, CPT codes 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 stated that MRI and electromyography do not match the examination findings or complaints. On appeal, the URA noted that ODG require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. Per the URA, the patient's MRI and electromyography/nerve conduction velocity fail to support the presence of radiculopathy.

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

ODG states that radiculopathy due to herniated nucleus pulposus but not spinal stenosis must be documented with objective findings on examination. The guidelines note that radiculopathy must be corroborated by imaging studies and/or electrodiagnostic studies, and patients should be initially unresponsive to conservative treatment such as exercises, physical methods, nonsteroidal anti-inflammatory medications and muscle relaxants. For this patient, the records do not indicate that he failed treatment such as nonsteroidal anti-inflammatory medications and therapy. On his most recent clinical examination, there was a lack of documentation of neurological deficits at the L5-S1 level. Additionally, the MRI of 1/16/13 fails to indicate that there is a neural compression at L5-S1. All told, the requested right transforaminal ESI L5/S1, CPT codes 64483, 64484 and 77003 is not medically necessary.

Therefore, I have determined the requested right transforaminal ESI L5/S1, CPT codes 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)**