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Notice of Independent Review Decision

DATE OF REVIEW: February 18, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar epidural steroid injection under fluoroscopy with IV sedation L3-L4.

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 and Pain Management.

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 lumbar epidural steroid injection under fluoroscopy with IV sedation L3-L4 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 1/10/14.
2. Notice of Assignment of Independent Review Organization dated 1/30/14.
3. Pre-Authorization Forms dated 10/08/13 and 11/14/13.
4. Denial documentation.
5. Lumbar myelogram and computed tomography dated 10/11/11.
6. Medical records dated 8/26/13, 9/09/13, 10/07/13, 11/04/13 and 12/02/13.
7. Lumbar imaging dated 7/21/11.
8. Magnetic resonance imaging (MRI) of the lumbar spine with and without contrast dated 12/22/09.

9. Medical records dated 3/18/10.
10. Medical records dated 7/12/13.
11. Clinic Referral Form dated 7/19/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male currently under consideration for authorization of a lumbar steroid injection under fluoroscopy with intravenous (IV) sedation at the level of L3-L4. The documentation submitted for review indicates the patient has a history of low back pain, buttock, and leg pain. Magnetic resonance imaging (MRI) of the lumbar spine on 12/22/09 indicated at the level requested for injection, that there was diminished T2 signal within the intervertebral disc, consistent with disc degeneration and desiccation. There was also a mild disc bulge indenting the ventral thecal sac, causing mild stenosis of the spinal canal with no evidence for neural foraminal compromise. This patient also underwent electrodiagnostic testing on 3/18/10, which revealed an impression of a bilateral S1 lumbar radiculopathy and no evidence for peripheral neuropathy, plexopathy, or entrapment. Follow-up evaluation on 8/26/13 indicated that prior conservative treatment included physical therapy, nonsteroidal anti-inflammatory medications, muscle relaxants and neuropathic pain medications. However, the patient's pain continued in a moderate to severe grade. Clinical notes from 12/02/13 indicated the patient continued to have persistent back, buttock, and leg pain. The records noted positive straight leg raise sign, decreased pinprick sensation in the L5 distribution, and decreased range of motion throughout the lumbar spine with pain on flexion. The patient has requested coverage for lumbar epidural steroid injection under fluoroscopy with IV sedation L3-L4.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA noted that the medical necessity for the L3-L4 epidural steroid injection cannot be established based upon the guidelines and/or clinical data submitted at this time. On appeal, the URA noted that given the issues with decreased success rates related to the patient's length of symptomatology combined with lack of effectiveness of medications, as well as the requested procedure being directed at the L3-L4 level for chronic S1 radiculopathy with no explanation why the L3-L4 level is being targeted, the requested services are not recommended.

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

The Official Disability Guidelines (ODG) support the recommendation for an epidural steroid injection to reduce pain and inflammation, thereby facilitating progress in more active treatment programs. Radiculopathy should be documented by physical examination with objective findings corroborated by imaging studies and/or electrodiagnostic testing. Further, the patient should be initially unresponsive to conservative treatments, which include exercises, physical methods, nonsteroidal anti-inflammatory medications, and muscle relaxants. Additionally, guidelines indicate that with regard to sedation, there is no evidence-based literature to make a firm recommendation as to sedation during an epidural steroid injection. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal.

A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. Therefore, routine use is not recommended except for patients with anxiety, and the least amount of sedation for the shortest duration of effect is recommended.

In this patient's case, there is no updated documentation submitted to indicate findings of clinically significant central canal stenosis, epidural fibrosis, or the presence of arachnoiditis. Further, there remains indication that the patient's medications have decreased ability in managing the patient's pain effectively. Based on the recommendation of the guidelines, chronic duration of symptoms greater than six months has been found to decrease success rates, with a threefold decrease in patients with symptoms of duration greater than 24 months. Additionally, there is a lack of documentation indicating the patient currently suffers with anxiety to support the recommendation for sedation. Given the above, the request for authorization for lumbar epidural steroid injection under fluoroscopy with IV sedation L3-L4 is not medically necessary.

Therefore, I have determined the requested lumbar epidural steroid injection under fluoroscopy with IV sedation L3-L4 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)