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**Notice of Independent Review Decision**

**DATE OF REVIEW:** January 28, 2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Bilateral L4-5 transforaminal epidural steroid injection (64483).

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

The requested bilateral L4-5 transforaminal epidural steroid injection (64483) is not medically necessary.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who reported a work-related injury on xx/xx/xx after she slipped and fell. The patient reports low back pain and has been treated with several medications to include anti-inflammatory medication, muscle relaxants, pain medication, topical analgesics, and anticonvulsants. On 12/9/14 the patient presented with complaints of persistent lower back and bilateral lower extremity pain. Upon physical examination, there was slight weakness of the extensor hallucis longus on the right and a positive straight leg raise on the right at 60 degrees. It was noted that the patient had attempted physical therapy without an improvement in symptoms. The patient continued to participate in a home exercise program without improvement. The patient was referred for bilateral L4-5 transforaminal epidural steroid injections.

The URA denial letter dated 12/29/14 notes that there was no documentation of asymmetric deep tendon reflexes consistent with significant radiculopathy. The URA further states that neuroforaminal narrowing was noted on MRI, however electrodiagnostic testing revealed no findings of radiculopathy. The URA further indicates that there was no documentation of failure of recent non-steroidal anti-inflammatory drugs or muscle relaxants.

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

According to Official Disability Guidelines (ODG) the patient does not meet criteria for bilateral L4-5 transforaminal epidural steroid injection. The ODG guidelines recommend epidural steroid injections as a possible option for the short-term treatment of radicular pain, with use in conjunction with active rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Patients should prove initially unresponsive to conservative treatment including exercises, physical methods, non-steroidal anti-inflammatory drugs, and muscle relaxants. According to the documentation provided, the patient has a history of lower back pain with bilateral lower extremity pain. Upon physical examination, the patient demonstrated mild weakness of the extensor hallucis longus on the right and a positive straight leg raise at 60 degrees. However, there was no evidence of a sensory deficit or reflex change in the bilateral L4-5 dermatomes. While it is noted that the patient has attempted physical therapy, the extent of treatment was not documented. There was no documentation of a recent attempt at conservative management. The magnetic resonance imaging (MRI) of the lumbar spine dated 7/24/14 revealed only mild left neural foraminal narrowing. The patient had a negative straight leg raise with intact sensation and normal motor strength on the left. All told, the medical necessity for bilateral transforaminal epidural injection has not been established. Based on the clinical information received and the ODG guidelines, the current request cannot be determined as medically necessary. In accordance with the above, I have determined that the requested bilateral L4-5 transforaminal epidural steroid injection 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)