

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 Medical Review Decision

Reviewer's Report

DATE OF REVIEW: May 20, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L5-S1 transforaminal epidural steroid injection with intravenous sedation (64483, 77003, 99144).

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)

The requested right L5-S1 transforaminal epidural steroid injection with intravenous sedation (64483, 77003, 99144) is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx. The office visit dated 3/30/15 documents the patient reports severe low back stiffness with intermittent episodes of right leg radiculopathy. The patient also reported that physical therapy exacerbates the pain. Physical examination noted positive straight leg raise on the right side at 45 degrees and positive dorsiflexion. Back pain was noted with straight leg raise. The left side straight leg raise was normal with no issues reported. Magnetic resonance imaging (MRI) of the lumbar spine dated

on 3/13/15 revealed spondylosis worse at L5-S1 with a disc protrusion, as well as a superimposed extruded and possibly sequestered disc fragment that appeared to impinge on the descending right S1 nerve root. The patient's provider recommended right transforaminal epidural steroid injection at L5-S1.

The URA denial letter dated 4/20/15 indicates that signs of radiculopathy on examination are absent and there is no indication of anxiety or phobia to support the request for intravenous sedation.

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 right L5-S1 transforaminal epidural steroid injection with intravenous sedation. 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 severe low back stiffness with intermittent episodes of right leg radiculopathy. The patient also reported that physical therapy would exacerbate the pain. The MRI performed on 3/13/15 was noted to reveal spondylosis worse at L5-S1 with a disc protrusion, as well as a superimposed extruded and possibly sequestered disc fragment that appeared to impinge on the descending right S1 nerve root. However, the neurological deficits found on physical examination did not match the pathology on MRI at the requested level for injection. The request did not specify that fluoroscopy be used for guidance. There was no documented plan for participation in an active treatment program following the injection. Additionally, the clinical documentation did not indicate that the patient suffered from anxiety or phobia to support the request for the intravenous sedation. All told, the medical necessity for right L5-S1 transforaminal epidural steroid injection with intravenous sedation 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 right L5-S1 transforaminal epidural steroid injection with intravenous sedation 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)**