Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Dec/11/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar transforaminal ESI

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
ODG Guidelines and Treatment Guidelines
MRI L/S, Dr., 6/8/09
EMG/NCS BUE/BLE, 8/10/09
Office notes, Dr., 9/18/09, 11/04/09
CM notes, 9/21/09, 10/8/09
Peer review, Dr. l, 10/19/09
DDE, Dr., 10/20/09
Peer review, Dr., 11/18/09

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male, reportedly injured on xx/x/xx when the front wheel of his truck was struck causing the steering wheel to spin in his hands in an opposite direction. He began treatment for the diagnosis of cervical and lumbar sprain. Treatment noted therapy, modified work activity, anti-inflammatory medication and pain medication. Lumbar MRI on 06/08/09 revealed multilevel changes causing mild canal stenosis from L2 to L5 to include facet arthrosis, ligamentum flavum hypertrophy, osteophytic ridging, and congenitally short pedicles. An incidental finding of a pelvic cyst was noted. EMG studies on 08/16/09 noted evidence suggestive of left C6-7 radiculopathy, left L5 radiculopathy with membrane

instability on the right in L4-5 and on the right at L5 but not significant enough to conclude radiculopathy. The impression was cervical and lumbar radiculopathy and lumbago. On examination, cervical and lumbar motion was guarded and limited with negative bilateral straight leg raise and neurovascular status intact to all extremities. Reflexes were intact. The claimant continued to report lumbar pain with numbness radiating along the lateral aspect of the right thigh and right lower leg. A right-sided L3-4 epidural steroid injection was requested.

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

The ODG guidelines recommend epidural steroid injections in effort to reduce pain and inflammation related radiculopathy. Individuals should have objective findings of radiculopathy. They should have failed conservative care. They can be used for both diagnostic and therapeutic purposes.

The records reviewed describe paresthesias into the upper extremities as well as pain into the right lower extremity. There is no objective evidence of radiculopathy on examination. The imaging studies do not reveal a clear-cut neurocompressive lesion, nor is there convincing history of subjective complaints that in themselves would be considered radicular in nature. As such, and in consideration of the evidenced-based ODG guidelines, there is no indication that epidural steroid injection would be reasonable or medically necessary in this setting. The reviewer finds that medical necessity does not exist at this time for Lumbar transforaminal ESI.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates, Low Back

Epidural steroid injections (ESIs), therapeutic: Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)