

Becket Systems

An Independent Review Organization
13492 Research Blvd. Suite 120-262
Austin, TX 78750-2254
Phone: (512) 553-0533
Fax: (207) 470-1075
Email: manager@becketsystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L5 and S1 Transforaminal Epidural Steroid Injection

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified in Pain Management and Anesthesiology, American Board of Anesthesiologists.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines

Adverse Determination Letters, 4/1/10, 3/12/10

Pain Management Center, 3/12/10, 3/3/10

Diagnostic Imaging, 12/28/09

Pain Consultants, 1/27/10

M.D., 1/19/10

PATIENT CLINICAL HISTORY SUMMARY

This patient complains of pain "in the right lower back that radiates down the right lower extremity with numbness and tingling all the way to the right foot." The patient also "has had several episodes of right leg weakness causing him to stumble over the last several weeks." Physical exam is significant for a positive straight leg raise on the right, 2+ DTR's on the left knee and ankle, 1+ DTR's on the right knee and ankle, 3/5 muscle strength with right 1st toe dorsiflexion, 5/5 muscle strength with left 1st toe dorsiflexion, and decreased sensation to neurosensory pinwheel testing in the right L5-S1 dermatomes compared to the left. MRI from 12/28/09 reveals L4-5 broad based disc bulge with severe neural foraminal narrowing and L5-S1 grade II anterolisthesis with moderate to severe loss of disc height and foraminal stenosis. EMG from 1/19/10 shows "pattern consistent with radiculopathy bilaterally at L5 and S1." The patient has failed physical therapy and medication management.

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

The records provided show the patient meets the criteria for ESI as outlined by the ODG. ESI is a short-term treatment for radicular pain. The patient has pain in dermatomal distribution with corroborative findings of radiculopathy. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned. The reviewer finds that medical necessity exists for Right L5 and S1 Transforaminal Epidural Steroid Injection.

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

MEDICAL JUDGEMENT, 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)