

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/05/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 visit ESI Lumbar Rt L3/4 x 1

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

M.D., Board Certified Anesthesiology

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

Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 10/25/11, 11/09/11
Peer review dated 08/30/11
Orthopedic report dated 10/11/11, 12/22/10
MMT/ROM testing dated 12/22/10
Lumbar MRI dated 10/13/10
Reference material
Initial evaluation dated 10/25/11
Initial medical report dated 12/23/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. He was carrying 2 blocks of sheet rock when he slipped but tried to resist the fall. Initially, he felt pain in the neck, mid back, low back and right shoulder. MRI of the lumbar spine on 10/13/10 revealed decrease in vertical disc height at L2-3 with mild disc desiccation and disc herniation with protrusion of the disc by approximately 2 mm. At L3-4 there is decrease in vertical disc height with mild disc desiccation; the facet joints are normal, and there is no significant central or foraminal stenosis. There is herniation of the disc by approximately 3 mm into the spinal canal. At L4-5 there is decrease in vertical disc height. Mild disc desiccation is seen. There is moderate osteoarthritis of the facet joints with no significant central or foraminal stenosis. There is moderate osteoarthritis of the facet joints at L5-S1. Orthopedic consult dated 12/22/10 indicates that the patient was initially x-rayed and prescribed physical therapy. Peer review dated 08/30/11 indicates that the patient underwent an interdisciplinary pain management program. There is no documentation that any of the current problems related to the shoulder or the back were caused by the injury itself. Peer review states medical probability the low back complaints relate to degenerative spondylosis of the lumbosacral spine, which is an

ordinary disease of life condition. No further care for the back is indicated for this condition. The outcome of the interdisciplinary care has been suboptimal as the patient has not returned to work and is still on the medications that he was on when he started. Orthopedic report dated 10/11/11 indicates that the patient was approved and scheduled for lumbar epidural steroid injection; however, his blood pressure was too high and the injection could not be performed. On physical examination there is decreased lumbar range of motion in flexion and extension. Straight leg raising is positive on the right and negative on the left. Motor strength is weaker in the right lower extremity. His reflexes are 2+ in the bilateral patella, 1+ left Achilles and absent right Achilles. Initial evaluation dated 10/25/11 indicates that on physical examination straight leg raising is negative for radicular symptoms in a seated position up to 90 degrees. There is intact light touch sensation at L4-5 and L5-S1 dermatomes bilaterally.

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

The URA review dated 11/09/11 indicates that the patient underwent surgical intervention on 03/11/11 followed by MRI of the lumbar spine on 07/22/11. There is no operative report or updated MRI study submitted for review. The submitted MRI dated 10/13/10 does not support a diagnosis of radiculopathy noting no significant central or foraminal stenosis at L3-4 or L4-5. There are conflicting physical examinations submitted for review. The exam performed on 10/11/11 noted positive straight leg raising on the right and decreased motor strength in the right lower extremity. However, physical examination on 10/25/11 reports that straight leg raising is negative for radicular symptoms and light touch sensation is intact at L4-5 and L5-S1 dermatomes bilaterally. The reviewer finds there is not a medical necessity at this time for 1 visit ESI Lumbar Rt L3/4 x 1. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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 KNOWLEDGBASE

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)