

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: March 3, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar epidural steroid injection

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

MD, Board Certified Anesthesiologist

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, Low Back Chapter
Notification of determination dated 12/30/10, 12/16/10
Fax cover sheet dated 12/13/10
Progress note dated 12/10/10
Procedure report dated 05/04/10, 07/29/09
Follow up note dated 07/22/10
MRI of the lumbar spine dated 03/06/09
Request letter dated 12/17/10
Telephone notes dated 12/16/10
Electrodiagnostic study dated 05/12/09
Utilization review notices, dated 12/16/10, 12/30/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was pushing a truck at work and injured his back. MRI of the lumbar spine dated 03/06/09 revealed degenerative disc disease at L5-S1 with bilateral neural foraminal narrowing and small annular tear at the L5-S1 posterior disc but no critical stenosis of the spinal canal appreciated. Facet degenerative changes are noted. Electrodiagnostic studies dated 05/12/09 revealed no electrical evidence of peripheral neuropathy, entrapment neuropathy, radiculopathy or other neuromuscular disease of the left leg.

The patient underwent bilateral facet injections at L4-5 and L5-S1 on 07/29/09. The patient underwent lumbar epidural steroid injection at L4-5 and L5-S1 on the left side on 05/04/10.

Follow up note dated 07/22/10 indicates that the patient continues to complain of some back pain despite having undergone an L5-S1 isolated lumbar laminectomy. Progress note dated 12/10/10 indicates that the patient presents with complaints of low back pain and left lower extremity radiculopathy. The patient reportedly underwent facet injections on 09/23/10. On physical examination the patient has lost a significant amount of weight secondary to depression. There are no neurological changes. Straight leg raising is positive at 20 degrees. He is still ambulating with a cane. The patient was recommended to undergo lumbar epidural steroid injection.

Request letter dated 12/17/10 indicates that the patient has not responded to conservative measures including physical therapy and medications. The initial request for lumbar epidural steroid injection was non-certified on 12/16/10 noting that there is insufficient objective evidence to support a diagnosis of radiculopathy. Documentation is not provided addressing conservative treatment. The denial was upheld on appeal on 12/30/10 noting that the patient underwent prior epidural steroid injection on 05/04/10 and the patient's response to this injection is not documented.

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

Based on the clinical information provided, the request for lumbar epidural steroid injection is not medically necessary. The patient underwent lumbar epidural steroid injection at L4-5 and L5-S1 on the left side on 05/04/10; however, the patient's objective, functional response to this injection is not documented. The Official Disability Guidelines support repeat epidural steroid injection only with evidence of at least 50-70% pain relief for at least 6-8 weeks. The patient's physical examination fails to establish the presence of active lumbar radiculopathy, and electrodiagnostic studies reported no evidence of radiculopathy. Given the current clinical data, the request for lumbar epidural steroid injection is not medically necessary.

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)