

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/04/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lumbar Transforaminal ESI @ Lt. L4-5

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

M.D., Board Certified Physical Medicine and Rehabilitation.

**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

Pre-authorization review final report 10/25/11

Pre-authorization review final report 11/09/11

Surgery pre-authorization form 10/20/11

Surgery pre-authorization form reconsideration 11/02/11

Progress note Dr. 10/17/11

History and physical Dr. 10/05/11

MRI lumbar spine 06/30/11

Progress note Dr. 05/24/11 and 09/15/11

Physical therapy progress note 05/23/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male whose date of injury is xx/xx/xx. His injury occurred due to a lifting episode. He complains of lower back pain and lower extremity radicular pain. MRI lumbar spine dated 06/30/11 reported L3-4 sizable left lateral recess annular tear and associated 3-4mm left paracentral to left lateral recess discal substance protrusion/herniation that mildly indents the thecal sac. At L4-5 there is a left paracentral annular tear and 3-4mm discal substance protrusion/herniation that mildly indents the thecal sac. At L5-S1 there is an asymmetrically prominent left uncovertebral joint marginal bony osteophyte of 4-5mm that mildly indents the thecal sac. The claimant was seen on 10/05/11 with subjective feeling of numbness in the left leg, but no feeling of weakness. Physical examination revealed paralumbar tenderness to palpation. Range of motion was moderately limited in each direction. Straight leg raise was negative bilaterally. Sensation was normal. Patellar tendon reflex was 2+, ankle reflex 0 bilaterally. Sensation was decreased in the left lateral calf. Ambulation was normal. Dr. saw the claimant for pain management consultation on 10/17/11. He was noted to have previously treated with physical therapy, NSAIDs and pain medication.

Physical therapy was effective in relieving pain. NSAIDs were effective. Pain medications were ineffective and made the claimant sick/dizzy. Physical examination reported sensation intact to pin prick in the extremities. Examination of the lumbosacral spine reported mildly reduced range of motion with mild pain on motion. Straight leg raise test was negative bilaterally. Faber's test was negative bilaterally. Strength was 5/5 throughout the right lower extremity. Muscle tone was normal. Reflexes were 2+ at the knees and ankles. Left lower extremity reported hip flexion strength 4/5, knee extension 4/5 flexion 5/5. Ankle dorsiflexion 4/5, plantar flexion 5/5. Patellar reflexes were 2+ and ankle reflex 2+. Gait was normal. Dr. recommended transforaminal epidural steroid injection.

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

This claimant complains of low back pain radiating to left lower extremity. He has failed to improve with physical therapy, pain medications, and NSAIDs. MRI of lumbar spine shows multilevel pathology of lumbar spine. At L4-5 there was a left paracentral annular tear and 3-4 mm disc protrusion / herniation that mildly indents the thecal sac. He has motor weakness to left lower extremity with equal and symmetrical reflexes at knees and ankles and sensation intact to pinprick in extremities. Per ODG guidelines for epidural steroid injections, radiculopathy must be documented with objective findings on examination present, and radiculopathy corroborated by imaging studies and / or electrodiagnostic testing. There is no evidence of neurocompressive pathology on MRI and no electrodiagnostic testing was documented. As such, the reviewer finds medical necessity is not established for Lumbar Transforaminal ESI @ Lt. L4-5.

**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)**