Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (207) 470-1075
Email: manager@becketsystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/08/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpt ASC Caudel Injection 62311 Lumbar

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. The reviewer finds the proposed Outpt ASC Caudel Injection 62311 Lumbar is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Report of medical evaluation / designated doctor's evaluation dated 01/06/10
Office visit notes Dr. dated 02/07/11-09/18/12
Report of medical evaluation dated 10/28/11
Progress notes Dr. dated 12/05/11-08/14/12
CT lumbar spine dated 06/05/12
MRI lumbar spine with and without contrast 06/06/12
Utilization review determination dated 09/12/12
Utilization review referral dated 09/24/12
Utilization review determination dated 10/09/12
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who sustained an injury to the low back on xx/xx/xx due to lifting a heavy drill bit. Records indicate he is status post umbilical hernia repair in 02/07 and abdominal hernia repair in 10/07. The claimant also underwent ACDF C6-7 on 04/27/07, and L5-S1 fusion in 10/08. Per office note dated 08/27/12 the claimant continued with neck pain radiating into both trapezius muscles, with right arm radicular symptoms that are intermittent and not very aggressive that quickly resolve with changes in position as primary source of

pain. He also complained of low back pain and lower extremity radiculopathy. Pain is noted to radiate along right groin and into the right testicle. Physical examination on this date revealed cervical spine has guarded motion that exacerbates in all movements. There is tenderness to palpation throughout all paraspinal muscles of right lateral deltoid. The upper extremities were motor intact with decreased sensation along C5 and C6 dermatome. There is hyperreflexia of upper and lower extremities. There is negative wrist and elbow Tinel's. The lumbar spine has guarded motion that exacerbates on extension, rotation, and flexion. There is tenderness over the distal paraspinous muscles with positive bilateral straight leg raise test. Lower extremities have quick fatigue of hip flexors and anterior tibialis, but otherwise they are muscularly intact. CT of lumbar spine on 06/05/12 revealed spondylolysis and spondylolisthesis at L5-S1, grade I-II with rod and pedicle screw fixation. There is foraminal elongation and asymmetric disc bulging to left contributing to severe left foraminal stenosis. There is wide patency of canal due to laminectomy at this level.

MRI of lumbar spine dated 06/06/12 revealed laminectomy with rod and pedicle screw fixation and grade II spondylolisthesis of L5-S1; foraminal elongation and disc bulging contributing to moderately severe bilateral foraminal stenosis with adequate capacity within the canal. It was noted similar findings on recent CT. The claimant was seen on 09/18/12 at which time it was noted neck pain continues to be main symptom with upper extremity radicular symptoms that are intermittent. Lumbar pain is also constant factor that is variable from 2-8 on scale of 0-10. Lower extremity radicular symptoms are also as progressive but not as easily reproducible along posterior and lateral aspect of thighs and lateral lower legs.

A request for ACS caudal injection lumbar 63211 was non-certified noting that guidelines indicate caudal steroid injection may be considered reasonable for those patients who have radicular pain and ongoing conservative care. Radiculopathy must be documented objectively on exam and corroborated by imaging studies and/or electrodiagnostic testing. Documentation submitted for review discussed lumbar MRI dated 06/06/12, but the MRI was not provided for review. As such, radiculopathy was not established by imaging studies and the request is non-certified.

Appeal request for outpatient ACS caudal injection 62311 lumbar was non-certified per review dated 10/09/12. Reviewer noted that physical examination documents guarded movement at the lumbar spine with hyperesthesia long the right lateral thigh and quick fatigue of both hip flexors; however, there is no specific documented objectified radiculopathy of decreased reflex or muscle atrophy. MRI of the lumbar spine obtained 06/06/12 indicates that at L3-4 there is mild disc bulge without focal neural foraminal impingement and no significant canal or foraminal stenosis. Criteria for use of epidural steroid injection note that radiculopathy must be documented with objectified physical examination findings, which need be present and corroborated by imaging study and/or electrodiagnostic study. There should be an initial unresponsiveness to conservative care of exercise, physical methods, non-steroidal anti-inflammatory medications and muscle relaxants. Without objectified clinical radiculopathy or nerve root impingement by imaging study, the request is non-certified.

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

The claimant sustained a lifting injury on xx/xx/xx. He underwent multiple surgical procedures including ACDS C6-7 and L5-S1 fusion. He continued to complain of primarily neck pain with upper extremity radiculopathy. He also complained of lumbar pain and lower extremity radicular symptoms. However, there was no evidence of a focal radiculopathy in the lower extremities on clinical examination. Imaging studies revealed post-operative changes at L5-S1 with rod and pedicle screw fixation, there was foraminal elongation and disc bulging with moderate to moderately severe bilateral foraminal stenosis, but no evidence of nerve root compression. As such, the request does not meet Official Disability Guidelines criteria for epidural steroid injection and the reviewer finds the proposed Outpt ASC Caudel Injection 62311 Lumbar is not recommended as 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

[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)