

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/24/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: LESI L3-4 L4-5 62311 77003
72275 62264

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for LESI L3-4 L4-5 62311 77003 72275 62264 is not recommended as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 02/06/13, 03/20/13
Procedure orders dated 02/01/13
Orthopedic consult dated 01/08/13, 02/12/13, 02/05/13
Letter dated 01/09/13, 11/28/12
Subsequent medical report dated 11/21/12
Peer review dated 12/02/12, 10/29/12
Office note dated 10/25/12, 10/16/12, 09/18/12, 08/21/12
Designated doctor evaluation dated 09/22/12
Note dated 08/30/12, 08/02/12
Manual muscle strength exam knee dated 02/12/13, 03/08/13, 03/01/13, 02/20/13, 02/05/13
MRI right knee dated 10/04/12
MRI right shoulder dated 07/26/12
Radiographic report dated 01/08/13, 06/20/12
Procedure report dated 12/11/12
Reference material, not dated
EMG/NCV dated 10/29/12
MRI lumbar spine dated 07/12/12

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/x/xx. On this date the patient tripped over a pipe in the kitchen and fell on her right side at work. MRI of the lumbar spine dated 07/12/12 revealed at L3-4 there is a focal right foraminal disc protrusion measuring 3 mm in height producing moderate right neural foraminal stenosis. At L4-5 there is moderate bilateral facet arthropathy. Note dated 08/02/12 indicates that the patient underwent two back operations xx years ago. The patient

underwent a course of physical therapy. Designated doctor evaluation dated 09/22/12 indicates that the patient reached MMI as of this date with 5% whole person impairment. Peer review dated 10/29/12 indicates that the treatment appears to have exceeded the compensable injuries. The claimant suffered contusions of the knee and ear and cervical area with head contusion and was placed at MMI per the designated doctor. EMG/NCV dated 10/29/12 revealed electro-physiologic evidence most consistent with a neuropathic lesion involving the lower trunk of the brachial plexus on the right with a superimposed distal sensorimotor median neuropathy (CTS) about the right wrist.

Peer review dated 12/02/12 indicates that the claimant's work related injuries included a right shoulder sprain/strain, lumbar sprain/strain, cervical sprain/strain, right elbow sprain/strain, thoracic sprain/strain, right knee sprain/strain, headaches, right ear contusion, abrasion of right fourth finger, rule out internal derangement of the right shoulder. All of these injuries should have resolved within 2-3 months. No further medical care is reasonable or necessary for her back injury. The patient subsequently underwent right S1 epidural steroid injection on 12/11/12. Orthopedic report dated 01/08/13 indicates that the injection gave her temporary relief. On physical examination motor strength is weaker on the right compared to the left, mostly due to the right knee. Straight leg raising elicited leg pain and back pain bilaterally, right side greater than left.

Initial request for LESI L3-4, L4-5 was non-certified on 02/06/13 noting that the claimant has no objective evidence of radiculopathy on physical examination with muscle atrophy, loss of relevant reflexes, or decreased sensation in a dermatomal distribution. The MRI of the lumbar spine reported no nerve root compression. The electrodiagnostic studies reported no lumbar radiculopathy. There is no documentation of 50-70% pain relief for six to eight weeks with increased function and decreased use of medications after the previous injection, as indicated by the guidelines. The denial was upheld on appeal dated 03/20/13 noting that the office note of 01/08/13 stated she had temporary relief after previous injection. The office note of 01/08/13 also contributed her right lower extremity weakness to her right knee injury. No additional documentation received related patient's response to physical therapy for the affected areas.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on xx/x/xx and underwent a course of physical therapy as well as right S1 epidural steroid injection on 12/11/12. The patient reported only temporary relief secondary to the injection. The patient's physical examination fails to establish the presence of active lumbar radiculopathy, and the submitted lumbar MRI does not support the diagnosis, as required by the Official Disability Guidelines. Designated doctor evaluation dated 09/22/12 indicates that the patient reached MMI as of this date with 5% whole person impairment. Peer review dated 10/29/12 indicates that the treatment appears to have exceeded the compensable injuries. The claimant suffered contusions of the knee and ear and cervical area with head contusion and was placed at MMI per the designated doctor. Peer review dated 12/02/12 indicates that the claimant's work related injuries included a right shoulder sprain/strain, lumbar sprain/strain, cervical sprain/strain, right elbow sprain/strain, thoracic sprain/strain, right knee sprain/strain, headaches, right ear contusion, abrasion of right fourth finger, rule out internal derangement of the right shoulder. All of these injuries should have resolved within 2-3 months. No further medical care is reasonable or necessary for her back injury. As such, it is the opinion of the reviewer that the request for LESI L3-4 L4-5 62311 77003 72275 62264 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

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)