

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/23/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L3-4 ESI, IV sedation, Fluoro

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Anesthesiology and Pain Medicine

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 an L3-4 ESI, IV sedation, Fluoro is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
MRI of the lumbar spine dated 11/21/12
Clinical note dated 01/28/13
Clinical note dated 02/05/13
Procedural note dated 02/12/13
Clinical note dated 03/01/13
Clinical note dated 03/11/13
Therapy note dated 03/21/13
Designated doctor evaluation dated 06/15/13
Clinical note dated 07/29/13
Clinical note dated 08/14/13
Adverse determinations dated 08/07/13 & 08/30/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his low back when he fell on xx/xx/xx. The patient noted immediate pain at the left hip and back. The MRI of the lumbar spine dated 11/21/12 revealed a subacute L3 anterior wedging compression fracture. The clinical note dated 01/28/13 mentions the patient having undergone a CT scan as well as the aforementioned MRI. The patient was also noted to have undergone 14 physical therapy visits with mild improvement. The patient noted increased pain with sitting, driving, lifting, and bending. The patient also reported difficulty sleeping if he twists to the left side. The clinical note dated 02/05/13 mentions the patient continuing with difficulty rising from a sitting position as well as driving. The procedural note dated 02/12/13 mentions the patient having undergone a percutaneous vertebral augmentation at L3. The clinical note dated 03/11/13 mentions the patient continuing with moderate back pain that was described as a sharp stabbing pain that was exacerbated with

bending and twisting. The note mentions the patient utilizing a lumbar brace which was noted to be helping considerably. The patient was able to demonstrate 75 degrees of forward flexion. The designated doctor exam dated 06/15/13 mentions the patient having been assigned a 10% whole person impairment rating. The clinical note dated 07/29/13 mentions the patient having 5/5 strength in the lower extremities bilaterally. Normal sensation was noted to light touch throughout the lower extremities as well. No reflex deficits were noted. The patient was recommended for an L3-4 epidural steroid injection at that time. The clinical note dated 08/14/13 mentions the patient having normal and intact motor, sensory, and reflexes bilaterally in the lower extremities. The patient was noted to have returned to work with light duty with a 25 lb. lifting restriction.

The previous utilization review dated 08/07/13 resulted in a denial for an L3-4 epidural steroid injection with IV sedation and fluoroscopic guidance secondary to no clinical findings indicating the need for an epidural steroid injection. Additionally, no information was submitted regarding the patient's extreme anxiety or needle phobia.

The utilization review dated 08/30/13 resulted in a denial as the clinical findings were noted to have non-radicular pain with intact sensation and a negative straight leg raise, not suggestive of a lumbar radiculopathy. Additionally, no information was submitted regarding the need for IV sedation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of low back pain. An epidural steroid injection would be indicated in the lumbar region provided the patient meets specific criteria to include significant clinical findings indicating radiculopathy. The patient is noted to have 5/5 strength with intact sensation and no reflex deficits in the lower extremities. Additionally, no imaging studies were submitted confirming the patient's neurocompressive findings. Given that no information was submitted regarding the patient's confirmation of a radiculopathy and taking into account that no information was submitted regarding the patient's imaging studies confirming the patient's neurocompressive findings as well as that no information was submitted regarding the need for IV sedation as no severe complaints of anxiety or a fear of needles was noted in the documentation, this request is not indicated as medically necessary. As such, it is the opinion of the reviewer that the request for an L3-4 ESI, IV sedation, Fluoro 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)