

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/18/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right lumbar sympathetic block

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 this reviewer's opinion that medical necessity has not been established for right lumbar sympathetic block

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a female whose date of injury is xx/xx/xx. When she stood up she felt her knee pop and give out. She complains of right knee pain. She was treated conservatively with physical therapy (pain relief minimal), TENS unit (really helps), and medication (Gabapentin helping with pain). Examination on 06/10/14 revealed positive straight leg raise on the right at 40 degrees, and MRI of the lumbar spine was ordered to rule out disc pathology. MRI dated 06/18/14 showed mild degenerative changes of the lower lumbar spine without significant canal or foraminal stenosis. The claimant was seen in follow-up on 06/24/14 with chief complaint of right knee pain. Physical examination reported the claimant to be 64" tall and 230 pounds. Straight leg raise was positive on the right at 40 degrees. There was tenderness to palpation medial and lateral right knee. Gait was antalgic. Neurologic/sensory exam reported allodynia not noted on previous examinations.

A request for right lumbar sympathetic block was reviewed on 07/01/14 and determined as not medically necessary, noting that there were no physical therapy notes provided for review documenting the amount of physical therapy completed to date and/or the claimant's response to any previous conservative care; no indication the claimant has been actively participating in a home exercise program.

A reconsideration request for right lumbar sympathetic block was reviewed on 07/07/14 and determined as not medically necessary, noting that there is no treatment history for the knee or diagnostic workup for the knee pain; findings are minimal on examination, and there are no patient subjective complaints of sympathetic findings either.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The claimant sustained an injury to her right knee secondary to a fall at work when her knee popped and gave out. She has consistently complained of right knee pain. Her most recent physical examination reported allodynia; however, there was no indication as to the region of this sensory change. There were no other examination findings indicative of complex regional pain syndrome (CRPS) such as temperature or color changes; mottling; hyperhydrosis; decreased range of motion; or motor weakness. The nature and extent of conservative care completed to date is not documented including the number of physical therapy visits, modalities used, and response to treatment. Based on the clinical information provided, it is this reviewer's opinion that medical necessity has not been established for right lumbar sympathetic block.

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)