

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/13/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar transforaminal epidural steroid injection @ L5-S1 using fluoroscopy

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

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 lumbar transforaminal epidural steroid injection @ L5-S1 using fluoroscopy is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 10/28/13, 12/18/13

Follow up note dated 10/08/13, 09/09/13

MRI lumbar spine dated 09/26/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as falling. Office note dated 09/09/13 indicates that the patient has undergone injections. The patient complains of low back pain and right leg pain. The patient is working full time. MRI of the lumbar spine dated 09/26/13 revealed at L5-S1 there is a mild 3 mm posterior annular disc bulge and endplate spurring and ligamentum flavum and articular facet hypertrophy is seen with mild bilateral neural foraminal stenosis; no significant spinal canal is identified. Follow up note dated 10/08/13 indicates that low back pain is his worst symptom. On physical examination strength is 5/5 on the left side, 4/5 right anterior tibialis and EHL and quadriceps. There is antalgic gait favoring the right leg.

Initial request for lumbar transforaminal epidural steroid injection at L5-S1 was non-certified on 10/28/13 noting that there is no documentation of a recent attempt at physical therapy services and a recent lumbar MRI did not reveal findings consistent with the presence of a compressive lesion upon a neural element in the lumbar spine. The denial was upheld on appeal dated 12/18/13 noting that the guidelines require objective evidence of radiculopathy on physical examination that is corroborated by imaging studies. The MRI reported no compression of the lumbar nerve roots and there is no documentation of lower levels of care of home exercise, physical methods, nonsteroidals, or muscle relaxants. There is no documentation from the previous epidural steroid injection of 50-70% pain relief for six to eight weeks or increased function.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on xx/xx/xx. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The submitted records indicate that the patient has undergone prior injections; however, there is no further information provided regarding prior procedures. The submitted physical examination fails to establish the presence of active lumbar radiculopathy, and the submitted lumbar MRI fails to document any significant neurocompressive pathology. As such, it is the opinion of the reviewer that the request lumbar transforaminal epidural steroid injection @ L5-S1 using fluoroscopy 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)