

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/20/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar left L3 transforaminal ESI

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 lumbar left L3 transforaminal ESI is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. On this date the patient reported left upper posterior buttock pain. The patient was seen and diagnosed with a lumbar strain. Note dated 11/21/13 indicates that the patient has completed 12 physical therapy visits to date. Pain level is rated as 3/10. The patient is noted to be making good progress. MRI of the lumbar spine dated 12/04/13 revealed at L2-3 there is mild posterior bulging of the annulus without significant spinal stenosis. The inferior aspect of the neural foramen is slightly narrowed on both sides related to bulging of the disc, but no compression of the exiting root sleeve is seen. At L3-4 posterior bulging of the degenerated disc is present. This produces an anterior extradural defect on the thecal sac and mildly narrows the central spinal canal. There is a moderate to large sized focal disc herniation along the left posterolateral disc margin. This is associated with moderate left L3 foraminal stenosis with crowding and perhaps mild flattening of the exiting root sleeve in the neural foramen. The right neural foramen is mildly narrowed by bulging of the disc, but no compression of the exiting root sleeve is seen. Progress note dated 01/07/14 indicates that on physical examination strength is 5/5 in the bilateral lower extremities. Deep tendon reflexes are 2+ bilaterally. Sensation is reduced over the mid to distal anterior thigh. New patient encounter dated 01/20/14 indicates that pain relief was minimal with prior blocks. On physical examination sensation is noted to be intact throughout.

Initial request for lumbar left L3 transforaminal epidural steroid injection was non-certified on 01/27/14 noting that there is indication that past injections provided only minimal relief. The current exam is devoid of any radicular findings. The denial was upheld on appeal dated 01/31/14 noting that physical examination dated 01/20/14 lacked compelling objective data substantiating radicular pathology. Physical examination revealed no muscle atrophy or

spasticity, intact sensations throughout, and no gait abnormality.

Per Official Disability Guidelines, a radiculopathy must be documented and objective findings on examination need to be present. Additionally, the documentation indicates that the patient has previously undergone physical therapy and blocks of an unspecified type with minimal to no results. Current guidelines recommend that the initial injections or previous injections produce pain relief of at least 50-70% for at least six to eight weeks prior to additional injections.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results prior to the performance of a lumbar epidural steroid injection. The patient's physical examination fails to establish the presence of active lumbar radiculopathy with intact sensation, motor and deep tendon reflexes. Additionally, per note dated 01/20/14, pain relief was minimal with prior blocks. There is no further information provided regarding these blocks to include dates of service and the types of blocks performed. As such, it is the opinion of the reviewer that the request for lumbar left L3 transforaminal ESI 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)