

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Feb/09/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** caudal epidural steroid injection

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., 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 for caudal epidural steroid injection is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as lifting a heavy item at work. The patient is noted to have a remote history of a laminectomy discectomy in the 1990s for left lower extremity pain. The patient underwent right sided L5-S1 laminectomy discectomy on 03/06/13. Designated doctor evaluation dated 08/15/13 indicates that the patient completed a course of postoperative physical therapy and returned to work without restrictions on 05/16/13. The patient was determined to have reached maximum medical improvement as of 05/16/13 with 5% whole person impairment. Office visit note dated 11/06/14 indicates that the patient complains of low back pain. He continues to report no return of radicular complaints. On physical examination lumbar range of motion is painful and restricted to the following: extension is painful at 25% of normal, rotation on the right is painful at 25% of normal. Lower extremities strength is symmetrically present in all lower extremity muscle groups. MRI of the lumbar spine dated 11/18/14 revealed previous bilateral hemilaminotomy at L5-S1 with or without microdiscectomy. There is moderate degenerative disc disease L5-S1 and very mild disc degeneration at other levels. At L1-2, L2-3 and L3-4 there is mild stenosis of the neural foramina. At L4-5 there is mild stenosis of the neural foramina and narrowing of the lateral recesses. At L5-S1 there is moderate stenosis of the right neural foramen, severe stenosis of the left neural foramen and probable compression of the traversing right S1 nerve roots. Office visit note dated 12/02/14 indicates that pain level is 4/10.

The initial request for caudal epidural steroid injection was non-certified on 12/12/14 noting that there is no documented radicular pain, sensory deficit or positive root tension sign to justify the requested caudal epidural steroid injection. The 05/16/14 report indicates that prior postoperative PT has been helpful. Any recent attempt with active rehabilitation was not recorded to indicate failure of conservative care. The denial was upheld on appeal dated 12/17/14 noting that an updated medical report addressing the issues of the previous determination was not submitted for review. Specific dermatomal/myotomal deficits attributable

to a nerve root impingement at L5-S1 are not noted. Definite diagnosis of radiculopathy at L5-S1 level cannot be ascertained to correlate with the MRI findings. Also, failure of recent conservative care with Physical Therapy was not documented.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries in January 2013. The most recent physical examination submitted for review is from November 2014. The terse physical examination provided in this note fails to establish the presence of active radiculopathy as required by the Official Disability Guidelines. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. Office visit note dated 11/06/14 indicates that the patient complains of low back pain. He continues to report no return of radicular complaints. Additionally, there is no indication that the patient has undergone any recent active treatment. As such, it is the opinion of the reviewer that the request for caudal epidural steroid injection is not recommended as medically necessary and the prior denials are upheld.

**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)