

# Becket Systems

An Independent Review Organization  
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**DATE NOTICE SENT TO ALL PARTIES:** Jun/04/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Lumbar ESI L4-5

**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 epidural steroid injection L4-5 is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. On this date he tried to open a manhole cover and felt a pull in his back when he lifted up. MRI of the lumbar spine dated 12/15/14 revealed at L4-5 there is a 0.5 mm bulge of annulus present not impinging upon neural structures. Exiting L4 nerve roots and descending L5 nerve roots are symmetrical. Facet joint space narrowing is noted bilaterally. The patient underwent transforaminal epidural steroid injection at L4-5 and L5-S1 on the right on 02/05/15. Designated doctor evaluation dated 02/06/15 indicates that the patient has not reached maximum medical improvement as he has just recently undergone a single epidural steroid injection and would likely benefit from further treatment. Progress note dated 02/10/15 indicates that the patient presents for follow up status post TFESI at L4-5 and L5-S1 on the right 5 days prior. His right sided hip pain and low back pain decreased significantly for the first 3 days following the injections. He is also having left sided low back pain and posterolateral left hip pain. On physical examination deep tendon reflexes are +2 bilaterally. Straight leg raising is negative. Progress note dated 03/18/15 indicates that the patient complains of continued low back pain. He had relief from the last procedure and is interested in receiving another injection. Current medications are alprazolam, Nexium and Zolpidem. On physical examination there is tenderness to palpation at the lumbar paraspinals bilaterally around L5-S1. Straight leg raising is negative bilaterally. There is decreased sensation to light touch on the L4-5 distribution on the right. Diagnoses are listed as facet arthropathy, lumbar syndrome, lumbar radicular syndrome, degenerative disc-lumbar and disc bulge lumbar.

The initial request for lumbar epidural steroid injection at L4-5 was non-certified on 03/25/15 noting that there is notation of "relief from last procedure and is interested in receiving another injection." There are questions in regard to what this procedure was, when it was performed and benefit in terms of percentage of relief and duration of relief and whether it was associated with increased function and decreased medication. The only objective evidence suggestive of radiculopathy is close decreased sensation to light touch on the L4-5 distribution on the right.

This does not correlate with imaging findings of MRI dated 12/15/14 which reveals no impingement upon neural structures at this level. Examination also reveals negative neural tension signs in the form of negative straight leg raising. Appeal letter dated 03/31/15 indicates that this is the first request for a lumbar epidural steroid injection at L4-5. The previous procedure was a transforaminal epidural steroid injection at L4-5 and L5-S1 on the right. The patient is now exhibiting symptoms bilaterally. There is an annulus bulge at L4-5. Although the MRI does not show impingement on the neural structures this does not account for possible inflammation in the area. The denial was upheld on appeal dated 04/30/15 noting that although the claimant has subjective complaints of radicular symptoms such as decreased sensation to light touch, the ODG requires that physical exam shows clinical signs of radiculopathy. The physical exams submitted for review show negative straight leg raising bilaterally, no atrophy and normal deep tendon reflexes bilaterally. In addition, the request is for an L4-5 epidural steroid injection and the MRI submitted for review states there is no nerve impingement at that level. The ODG requires that diagnostic imaging corroborate with the radicular findings.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries on xx due to lifting a manhole. There are no serial physical therapy records submitted for review documenting the nature and extent of conservative treatment completed to date. The Official Disability Guidelines require documentation of participation in conservative treatment prior to the performance of lumbar epidural steroid injection. The Official Disability Guidelines also require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active radiculopathy, and the submitted lumbar MRI fails to document any significant neurocompressive pathology at the requested level. As such, it is the opinion of the reviewer that the request for lumbar epidural steroid injection L4-5 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)