

Becket Systems

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DATE NOTICE SENT TO ALL PARTIES: Mar/14/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left L4 & L5 Transforaminal ESI

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 this reviewer's opinion that medical necessity for the requested Left L4 & L5 Transforaminal ESI is not established

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a female who was injured on XX/XX/XX when she struck a bump driving a X which caused low back pain. The claimant was found to have a disc herniation at L5-S1 impressing on the L5 and S1 nerve roots. The claimant did undergo a left L5 transforaminal epidural steroid injection on XX/XX/XX. The XX/XX/XX clinical report noted only 30% improvement following the epidural steroid injection. The physical exam on XX/XX/XX noted sensory loss in the left calf and foot. There was a straight leg raise to the left at 35 degrees. Mild weakness was present at the left ankle. The patient was recommended for a left S1 epidural steroid injection at this evaluation. The prior denial rationale for the L4-5 epidural steroid injection was not available for review.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical records provided for review does not support the submitted epidural steroid injection request at L4-5. The XX/XX/XX evaluation specifically noted recommendations for a S1 epidural steroid injection. It is unclear why the request now is for a left L4-5 epidural steroid injection. The records clearly note poor response to the prior left L5 epidural steroid injection to support repeating an injection at this level. As the clinical documentation provided for review does not meet guideline recommendations for the requested service, it is this reviewer's opinion that medical necessity for the requested Left L4 & L5 Transforaminal ESI is not established and the prior denials remain 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)