Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (512) 366-9749
Email: manager@becketsystems.com

08/27/18

Description of the service or services in dispute:

XX

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified PM&R –
Board Certified Pain Medicine

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX diagnosed with XX XX change In the XX XX; XX. XXXX stated XXXX first started having pain in XXXX while XXXX. XXXX stated XXXX had immediate XX-sided XX and XX pain. XXXX was working as a XXXX at the time of injury.

XXXX was evaluated by XXXX on XXXX for follow-up of XXXX XX shoulder, XX, and arm pain. XXXX was status post repeat shoulder surgery with XXXX on XXXX. XXXX felt XXXX was having some slow improvement form this. XXXX continued with XX XX and radiating shoulder pain. XXXX had attempted to get XX epidural steroid injection approved, but this had been denied several times for different reasons. Imaging of the XX had revealed XX XX in XXXX XX area that might be causing XXXX XX, shoulder, and arm pain as well. XXXX complained of pain in XXXX XX XX area that radiated down XXXX XX XX and shoulder down

XXXX XX arm into XXXX XX XX fingers. XXXX had associated numbness with this. XXXX had not been able to work since XXXX after XXXX injury, but XXXX felt XXXX XX arm was not as strong as XXXX XX and had difficulty raising XXXX XX arm above shoulder level. XXXX stated XXXX was basically not able to use the XX arm because of the pain in XXXX XX, shoulder, and arm. XXXX had been referred to XXXX for performance of a XX-XX and XX-XX XX epidural steroid injection for hopeful reduction of XXXX XX and arm pain. XX XX examination showed positive tenderness to palpation in the XX XX muscles as well as XX area. There was continued positive XX on the XX. There was continued positive pain with abduction and a positive XX XX XX (improved from prior). There was some continued decreased sensation to light touch on the XX forearm compared to the XX side. Strength was 3-4/5 in the XX XX extremity compared to the XX and 5/5 in the remaining extremities. Deep XX reflexes were 1-2+ XX XX. XXXX assessed XXXX had XX-sided XX pain, shoulder pain, and arm pain secondary to XX XX / strain and XX shoulder derangement.

An MRI of the XX shoulder dated XXXX showed progressive XX changes involving the XX XX XX. There was worsening XX XX XX loss and generalized XX loss along the XX head. It also showed mild XX XX XX. There was small re-tear of the XX XX XX. The study also showed mild progression of the XX with small XX and XX-XX tear of the XX. There was no full-thickness or retracted cuff tear.

An MRI of the XX XX without contrast dated XXXX showed a XX XX change in the XX XX. XX. XX. There was nonspecific heterogenous appearance of the XX XX of the XX XX. This was to be correlated for XX XX.

Treatment to date included medications (XXXX), physical therapy, injections in shoulder / XX, XX shoulder XX repair, epidural steroid injection by XXXX using a catheter (provided some relief, however, XXXX pain returned), and shoulder surgery.

Per utilization review decision letter and peer review dated XXXX, the request for XX XX epidural steroid injection under XX with monitored sedation at XX-XX was denied as it did not meet established standards of medical necessity. The decision was made by XXXX with the following rationale: "Per Officially Disability Guidelines, epidural steroid injections are not medically recommended based on the recent evidences, given the serious risks of this procedure in the XX region and lack of quality evidence for sustained benefit. This treatment had been recommended as an option for treatment of XX pain (defined as pain in XX), with specific criteria for use below. XX must be documented by physical examination and corroborated by imaging studies and / or electrodiagnostic testing. XX imaging is inconsistent with XX XX XX. No electrodiagnostic testing is noted. A successful peer-to-peer call with XXXX was made. During the conversation, it was confirmed that the patient has not had more recent imaging or an XX. It was discussed that the imaging findings are not

consistent with XX level XX XX. Medical necessity has not been established. Therefore, the requested XX XX epidural steroid injections under XX with monitored sedation at XX-XX is not medically necessary."

Per a utilization review determination letter dated XXXX, an appeal for XX XX epidural steroid injection under XX with monitored sedation at XX-XX was not certified. It was noted, "XX-XX filed XXXX, on extent carrier disputes that the compensable injury extends to include XX to include XX XX-XX, XX-XX XX XX XX and XX, which represent pre-existing, ordinary disease of life and not directly and causally related to the work-related accident." XXXX provided the following rationale for the denial: Per ODG - XX and XX XX (updated XX), epidural steroid injection (ESI) was not recommended based on recent evidence, given the serious risks of this procedure in the XX region and the lack of quality evidence for sustained benefit. This treatment had been recommended as an option for treatment of XX pain (defined as pain in XX XX with corroborative findings of XX), with specific criteria for use below. See XX XX-XX XX. See also the XX XX Chapter, where ESIs were recommended as a possible option for short-term treatment of XX pain in conjunction with active rehabilitation efforts, but they were not recommended for XX XX or for nonspecific XX XX pain. A successful peer-to-peer call with XXXX on behalf of XXXX occurred on XXXX, and it was discussed that there was previous adverse determination dated XXXX whereby the previous reviewer noncertified the request for XX XX epidural injection under XX with monitored sedation at XX-XX. The patient had XX shoulder pain and a documented injury to that shoulder on MRI scan. However, it was clear from ODG and standard practice guidelines that XX epidural steroid injection above XX-XX, as well as, any XX transforaminal epidural steroid injection represented a significant risk to patients and are not recommended. Therefore, the request, for XX XX epidural steroid injection under XX with monitored sedation at XX-XX was not medically necessary.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Based on the clinical information provided, the request for XX Office/outpatient visit, est is not recommended as medically necessary, and the previous denials are upheld. The Official Disability Guidelines note that XX epidural steroid injections are not recommended based on recent evidence, given the serious risks of this procedure in the XX region, and the lack of quality evidence for sustained benefit. Additionally, the submitted clinical records indicate that the patient underwent prior XX epidural steroid injection; however, the patient's objective functional response to this procedure is not documented. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

☐ ACOEM-America College of Occupational and Environmental Medicine
☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
☐ DWC-Division of Workers Compensation
☐ Policies and Guidelines European Guidelines for Management of Chronic Low Back Pain
☐ Interqual Criteria
☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
☐ Mercy Center Consensus Conference Guidelines
☐ Milliman Care Guidelines
☑ ODG-Official Disability Guidelines and Treatment Guidelines
ODG: XX and XX XX Chapter:

XX
XX

☐ Pressley Reed, the Medical Disability Advisor
☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.