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

Review Outcome

Description of the service or services in dispute:

XX epidural injection targeting XX, XX greater than XX at the XX, XX-XX levels with an entry point at the XX-XX level.

XX: Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, XX, XX, XX, other solution), not including XX substances, including needle or catheter placement, XX epidural or XX, XX or XX (XX); without imaging guidance
XX: Fluoroscopic guidance and localization of needle or catheter tip for XX or XX diagnostic or therapeutic injection procedures (epidural or XX) (List separately in addition to code for primary procedure)

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

Board Certified Anesthesiology

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)

XX. XX XX is a XX-year-old XX who sustained an injury on XX. XX reported injury to the XX, posterior XX / XX, XX, and XX region, which was caused when XX XX to XX XX in a XX that XX XX from XX XX XX XX to XX XX XX the XX on the XX of XX XX XX followed by XX on the XX XX and XX on XX XX. XX heard a crunching noise in the XX when XX XX the XX and reported it felt like XX XX something in XX XX. XX was diagnosed with contusion of other part of XX, initial encounter (XX.XX), strain of muscle, XX and tendon at XX level, initial encounter (XX), sprain of ligaments of XX XX, initial encounter (XX.XX), sprain of ligaments of XX XX, initial encounter (XX.XX), and strain of muscle and tendon of XX wall of XX, initial encounter (XX.XX).

XX XX, XX evaluated XX. XX on XX for XX, XX XX, XX XX, and XX XX pain. The pain was described as aching, sharp, stabbing, and throbbing in nature. XX. XX reported that the pain was tolerable with the ongoing medications. The pain was rated at 4/10 with medications and 10/10 without medications. The XX XX pain radiated down the XX XX XX. The XX pain radiated down the XX XX and XX. XX also complained of tingling over the XX XX with some weakness in the XX XX. XX was able to perform normal activities and to work. Examination of the XX XX revealed positive XX test and positive XX compression test. Examination of the XX XX revealed tenderness to palpation over the XX XX muscles and XX muscles XX, positive straight XX raising test XX. Neurological examination revealed positive sensory deficit to pinprick and temperature sensation at the XX XX, XX, XX, and XX XX, XX, and XX XX distribution. Deep tendon reflexes were 0 at XX, 0-1 at XX, 1+ at XX XX, and 0-1 in the XX XX.

A XX XX MRI dated XX showed mild central XX XX at XX-XX. At XX-XX, there was mild central XX XX with mild XX neural XX XX. At XX-XX, there was a broad-based posterior XX XX XX measuring XX mm antero-posterior (AP), which flattened the anterior aspect of the XX XX. There was also mild central XX XX. At XX-XX, there was a broad-based posterior XX XX XX measuring XX to XX mm AP, which flattened the anterior aspect of the XX XX. There was also mild central XX XX. At XX-XX, there was a broad-based posterior XX XX XX measuring XX mm AP, which flattened the anterior aspect of the XX XX. An MRI of the XX XX dated XX revealed diffuse XX XX measuring up to XX mm in the neural XX regions XX at XX-XX, which resulted in mild XX neural XX XX. There was a diffuse XX XX measuring up to XX mm in the XX neural XX region at XX-XX. This diffuse XX XX resulted in moderate-to-severe XX and moderate XX neural foraminal XX. At XX-XX, there was a diffuse XX XX measuring up to XX mm. A XX XX x-ray dated XX revealed small XX body XX at XX-XX. An MRI of the brain dated XX showed no XX XX nor any abnormality in the XX. X-rays of the XX XX, XX XX, and XX dated XX were normal.

Treatment consisted of medications (XX, XX, XX XX, XX, XX, XX, and XX) with relief, failed XX therapy, home exercise program, and soft XX XX.

Per a utilization review determination letter dated XX, the request for XX epidural injection targeting XX, XX greater than XX at the XX and XX-XX levels with an entry point at XX-XX was denied by XX XX, XX. Rationale: "The principal reason(s) for denying these services or treatment: XX epidural injection XX XX greater than XX XX, XX-XX levels with an entry point at XX-XX is non-certified, not medically necessary and not within the ODG guidelines. The clinical basis for denying these services or treatment: request is not medically necessary. Per a conversation with XX. XX, this request does not meet the criteria for approval as there no extenuating circumstances to support the request. The patient has failed therapy in the XX and XX XX. After talking with the provider, no extenuating circumstances were described. Per ODG guidelines, CESIs are not recommended. Therefore, the request is not medically necessary."

Per a utilization review determination letter dated XX, the request for XX epidural injection targeting XX, XX greater than XX at the XX and XX-XX levels with an entry point at XX-XX was not approved by XX. Rationale: "The following request has been reviewed by a physician advisor and has been determined not medically necessary because request is not medically necessary. Per conversation with XX, this request does not meet the criteria for approval as there was lack of objectivity confirmable evidence of pain e either with symptoms or finding. The provider stated that the patient has positive sensory deficit to pinprick. The patient does not fully meet the criteria per ODG guidelines. There was a lack of objectivity confirmable evidence of radiculopathy either with symptoms or finding. Therefore, all of the above requests are not supported."

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

The patient presented with radiating XX XX pain to the XX. There was both sensory loss and documented motor weakness in the XX XX Reflexes are XX. Conservative therapy has failed including XX therapy, chiropractic. Medication provides about 50% pain relief. The MRI is grossly abnormal showing XX XX, XX and XX XX, at levels which correlate with the presenting clinical features. Two prior reviews cited a lack of objective information in support of an ESI A peer to peer was conducted in XX – limited information is provided as to why the reviewer could not establish the presence of extenuating circumstances. The documentation demonstrated by the provider is accurate and thorough, and appear to fulfill the ODG criteria, with extenuating factors present. Given the documentation available, the requested service(s) is considered 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 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 XX 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
- ☐ 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 XX 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.