

Becket Systems

An Independent Review Organization
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DATE OF REVIEW:

May/13/2009

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Lt C6-C7 C7-T1 Transforaminal ESI with Fluoroscopy (64479, 64480, 77003, 99144)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

MD, Board Certified in Anesthesiology and Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Determination Letters, 4/6/09, 3/9/09

MD, 3/30/09, 2/13/09, 1/14/09, 11/20/08, 9/25/08, 4/23/08, 1/17/08, 9/19/07, 8/15/07

MRI Cervical Spine w/o contrast, 12/19/08

MRI Thoracic Spine w/o contrast, 12/19/08

2/18/09, 3/25/09

8/21/07

Operative Note, 3/8/07

ODG-TWC, Neck & Upper Back, Epidural Steroid Injection

PATIENT CLINICAL HISTORY SUMMARY

The claimant underwent cervical discectomy and fusion in xxxx. Cervical MRI in December 2008 showed C4-7 fusion and multi-level spondylosis. Physical examinations show pain in the neck, but no neurological deficits, no muscle weakness, and no pain along a nerve-root path. Cervical ESI was performed on February 13, 2009. Follow-up visits did not indicate significant improvement in symptoms.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Cervical ESIs have been used to treat pain associated with acute disk herniation and radiculopathy. This patient has regional neck pain with no clear evidence of radiculopathy. In addition, she has already received an ESI with no documentation of any significant benefit documented in the medical records. For these reasons, this request does not meet the ODG criteria for ESI. The reviewer finds that medical necessity does not exist for Lt C6-C7 C7-T1 Transforaminal ESI with Fluoroscopy (64479, 64480, 77003, 99144).

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)