

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CESI #3 @ C6-7 (Betadine Allergy) (62310)

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

M.D., 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

Preauthorization Determination Letters, 4/12/10, 4/29/10

M.D. 4/9/10

3/25/10, 3/4/10

D.O. 4/6/10, 3/12/10, 2/22/10, 4/19/10

2/11/10

ODG

PATIENT CLINICAL HISTORY SUMMARY

The patient complains of "neck pain radiating" per 4/19/10 office visit note. Patient is status post 2 cervical ESI's (DOS 3/4/10 and 3/25/10). The patient reported "50% improvement of symptoms" on 3/12/10 and "continued improvement" on 4/6/10. The request for a 3rd ESI was made on 4/6/10 (approximately 2 weeks after the 2nd ESI on 3/25/10).

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

Per the ODG, "Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase." This would be considered a 3rd injection in the series. In addition, a therapeutic ESI is not indicated unless 50% pain relief is obtained for 6 to 8 weeks. It is unclear from the records provided if the second injection of 3/25/10 has provided 50% pain relief for the 6-8 week timeframe. The request does not conform to the ODG Guidelines and Treatment Guidelines, and there were no reasons given explaining to this

reviewer why a divergence from the guidelines would be appropriate in this case. The reviewer finds that there is not medical necessity for CESI #3 @ C6-7 (Betadine Allergy) (62310).

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)