

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/09/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Transforaminal Epidural Steroid Injection @ Right C6-7 using Fluoroscopy, #1

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

M.D., Board Certified, Neurological 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines - Treatment in Workers Compensation, Neck and Upper Back Injury Management Organization, Denial Letters 10/21/11, 11/09/11
Dr., 04/13/11-10/12/11
MRI cervical spine, 07/13/11
Dr. 07/07/11, 07/14/11
Radiographic report cervical spine, 05/23/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who presented with complaints of cervical pain with radiation into right upper extremity. She has complaints of numbness and tingling in right fingers and weakness in right arm. She is pending results from BRC hearing. She is 63 inches tall and weighs 119 lbs. She is well developed and well nourished. Motor strength is 5/5. Deep tendon reflexes are normoactive. Sensory is intact in upper and lower extremities. Shoulder range of motion is limited due to pain. Cervical range of motion is limited in all planes. There is evidence of tenderness and spasm. She has prescriptions for Soma 350 mg, Norco 10/325 and Daypro 600 mg. She is a candidate for surgery regarding her shoulder. She was referred for radiographs on 05/23/11, which showed no acute abnormality. She exacerbated her injury and was referred for MRI of cervical spine. This study performed on 07/13/11 notes very minimal disc bulge at C3-4. At C5-6 there is a shallow right paracentral disc bulge indenting the thecal sac and spinal cord slightly resulting in mild canal stenosis. There is uncovertebral hypertrophy slightly narrowing the foramen. At C6-7 there is a shallow right paracentral disc protrusion, which minimally indents the thecal sac. There is mild canal stenosis. are patent. On 07/07/11, the claimant saw Dr. She had intact motor strength. Reflexes were 1+ and symmetrical. She had not yet had an MRI scan on cervical spine and so Dr. recommended that she undergo this study. On 07/14/11 Dr. followed up. He reviewed

the MRI scan and was of the opinion that it was normal. Dr. recommended that the claimant seek advice from an orthopedic surgeon as she may have rotator cuff problem. Dr. next saw the claimant. The most recent physical examination indicates intact motor strength. Deep tendon reflexes are normoactive. Sensory is intact in upper and lower extremities. She was recommended to undergo cervical epidural steroid injection at C6-7.

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

This claimant has history of neck and shoulder pain as result of a work place injury. Imaging studies of her cervical spine fail to indicate presence of disc herniation with neural compression.

The claimant's serial physical examinations showed no overt evidence of cervical radiculopathy. Motor, sensory and reflex testing is within normal limits. There is an absence of objective findings on physical examination. The ODG criteria for ESI is not satisfied according to the records provided for this review. Therefore, and based upon the evidence-based guidelines, this request for Cervical Transforaminal Epidural Steroid Injection @ Right C6-7 using Fluoroscopy, #1 is not 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 & 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)