



Specialty Independent Review Organization

AMENDED REPORT – 1/15/2008

DATE OF REVIEW: 12/31/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under review include a bilateral cervical rhizotomy at C3 to C7.

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

The reviewer is a board certified physical medicine and rehabilitation physician who has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr. and from the URA.

These records consist of the following (duplicate records are only listed from one source): Dr.: 3/4/03 cervical MRI, 7/23/03 Hx and Physical by Dr., 8/5/03 note by Dr., 8/5/03 operative note, 8/5/03 discharge note, pain management progress note 8/12/03, 6/30/05 cervical MRI and 3/20/06 to 5/8/06 notes (physical, procedure and discharge) by Dr.

10/5/07 denial letter, 10/2/07 precert letter, 8/15/06 cervical CT, 3/31/03 consultation D., MD, CESI reports 4/16/03 to 11/11/03, 1/14/04 to 4/28/04 facet block reports, 11/7/07 denial letter, 10/30/07 precert request and letter and 9/25/07 note by PA.

We did NOT receive a copy of the ODG from the URA or carrier for this case.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured while performing her job duties. She has undergone cervical ACDIF C4-C6 by Dr.. She has neck and left shoulder pain as well as headaches.

A radiofrequency ablation at C3 to C7 bilaterally is proposed by Dr. She has undergone Botox injections for myofascial pain in 2006; left cervical facet medial branch blocks times 3 in 2004 and Cervical ESI times 3. She has been diagnosed with cervical pain and degenerative disc disease.

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

According to the ODG the following are the criteria for this procedure:

1. Treatment requires a diagnosis of facet joint pain. See Facet joint diagnostic blocks.
2. While repeat neurotomies may be required, they should not be required at an interval of less than 6 months from the first procedure. Duration of effect after the first neurotomy should be documented for at least 12 weeks at $\geq 50\%$ relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.
3. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
4. No more than two joint levels are to be performed at one time (See Facet joint diagnostic blocks).
4. If different regions require neural blockade, these should be performed at intervals of not sooner than one week, and preferably 2 weeks for most blocks.
5. There should be evidence of a formal plan of rehabilitation in addition to facet joint therapy.

None of the criteria are met in this case. A diagnosis of facet joint pain has not been verified. Cervical facet joint medial branch blocks were done by Dr. in the past; however, there is no documentation to verify a therapeutic response to the last attempt done on 4/18/04.

Documentation of duration of effect of branch blocks has not been offered for review. Intervention at greater than 2 levels and both sides is being requested. Only one side appears to be affected based on the limited documentation provided from the parties.

Regarding criteria 5, no evidence of a formal plan for coordinated rehabilitation is provided for review. Therefore, the proposed procedure is not found to be medically necessary at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)