



Notice of Independent Review Decision

DATE OF REVIEW: 7/24/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness of the previously denied request for cervical facet joint injections at level C2 to C5 with anesthesia and fluoroscopic guidance.

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

Texas Licensed Pain Management/Anesthesiology Specialist.

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 previously denied request for cervical facet joint injections at level C2 to C5 with anesthesia and fluoroscopic guidance.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Fax Cover Sheet dated 6/27/07.
- Notice to CompPartners, Inc. of Case Assignment dated 6/27/07.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 6/25/07.
- Request for Independent Review Organization dated 6/25/07.

- **Request for a Review by an Independent Review Organization dated 6/18/07.**
- **Note dated 6/22/07.**
- **Response Letter dated 6/29/07.**
- **Notification of Determination dated 5/22/07.**
- **Utilization Review Decision Notification dated 6/1/07.**
- **Provider Data List (unspecified date).**

PATIENT CLINICAL HISTORY [SUMMARY]:

Age:

Gender: Female

Date of Injury:

Mechanism of Injury: Lifting a mop bucket.

Diagnosis: Status post C5-C6 fusion, cervical spondylosis, cervical disc disease with spinal stenosis, and enthesopathy

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

The patient is a female who sustained a work-related injury involving the cervical spine, secondary to lifting a mop bucket. Subsequent to the injury, the claimant underwent an anterior cervical fusion at level C5-C6 on 8/23/05. This patient's current complaints included numbness and tingling to the right arm/hand. Other conservative treatment performed included facet injections, trigger point injections, acromioclavicular injection (side not specified), and physical therapy. Current medication management consisted of methadone, Norco, and Parafon Forte. Reportedly, clinical examination revealed tenderness over the right upper cervical facet C2-C5 and graded by ipsilateral extension. The current diagnoses included status post C5-C6 fusion, cervical spondylosis, cervical disc disease with spinal stenosis, and enthesopathy. After review of the limited information submitted, the request for cervical facet joint injections has been denied. It appears to this reviewer that the patient was noted to have features of a diagnosis of failed neck surgery syndrome and not facet syndrome. The requested procedure is not likely to provide sustained pain relief in this claimant's radicular symptoms. The clinical indication and necessity for the request could not be established.

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 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.
