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Notice of Independent Review Decision

DATE OF REVIEW: 12/29/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Radiofrequency Neurotomy C2-3, C6-7

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

Licensed in Physical Medicine & Rehabilitation

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Radiofrequency Neurotomy C2-3, C6-7 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Progress Notes, Unknown Provider, 11/13/06, 12/07/06, 05/02/07, 11/12/07, 12/05/07, 12/20/07, 04/21/08, 07/09/08, 07/11/08, 08/22/08, 08/26/08, 09/03/08, 09/04/08, 09/05/08, 09/15/08, 10/01/08, 10/06/08, 10/10/08, 10/16/08, 10/28/08

- Examination Evaluation, , M.D., 11/12/07, 04/21/08, 09/15/08
- PM Epidural – Cervical, Dr. , 12/20/07, 06/26/08
- Letter regarding preauthorization from Dr. , 07/11/08, 08/26/08
- Preauthorization Request for Outpatient Procedure, 08/22/08, 10/06/08, 10/28/08
- Adverse Determination, 10/06/08, 10/22/08, 10/28/08
- Notice to URA of Assignment of IRO, 12/08/08
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient's complaints consisted of severe persistent cervical and scapula pain as well as bilateral arm pain. MRI's were performed and he has also received two epidurals. His most recent medications were noted to be Norco, Lyrica, and Celexa.

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

Per criteria set forth by Official Disability Guidelines, a medical necessity for a radiofrequency neurotomy has not been established. The above-noted reference indicates that if therapeutic procedures are to be performed to the cervical facet joints, there must be documented signs and symptoms consistent with a cervical facet mediated pain syndrome, and there must be no evidence of a cervical radiculopathy. The records available for review do document the presence of signs and symptoms on physical examination consistent with a cervical radiculopathy. Additionally, prior to consideration of a radiofrequency neurotomy procedure, diagnostic medial branch blocks are typically performed to confirm the presence of a facet joint mediated pain syndrome. The records available for review do not document that there has been a recent attempt at treatment in the form of cervical medial branch blocks. Thus, per criteria set forth by the above-noted reference, based upon the records presently available for review, medical necessity for treatment in the form of a radiofrequency neurotomy from the C2/C3 to C6/C7 levels would not appear to 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 & 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)**