



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

Workers' Compensation Health Care Network (WCN)

Original decision date: 06/23/2008

Amended decision date: 06/24/2008

DATE OF REVIEW: 06/23/2008

AMENDED DATE: 06/24/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right C3-C6 RFTC

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

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.

PATIENT CLINICAL HISTORY:

This is a xx-year-old female who sustained a work-related injury on xx/xx/xx involving the cervical spine, thoracic spine, lumbar spine, bilateral knees/right hip secondary to a slip and fall mechanism. This claimant had been diagnosed with cervical spondyloarthritis and had undergone anterior cervical fusion at the C4-5 level. This claimant reportedly has multiple areas of complaints but pertaining to this request, she has had right-sided neck pain radiating into the occipital and parietal scalp regions associated with symptoms of crepitus, headaches, and neck stiffness.

According to the Utilization Review Determination Report dated April 28, 2008, the patient has had previously performed facet joint injections with reportedly 75% relief of pain. The treating physician has recommended to proceed with cervical rhizotomy to include the levels of where patient had a previous cervical fusion at C4-5.

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

After reviewing the information submitted, it is the opinion of this reviewer that the previous non-authorization be overturned with a certification to proceed with radiofrequency ablation (RFTC) right-sided cervical levels C-3 and C-6. The above procedure appears to be medically



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appropriate and necessary and should result in substantial decrease in the patient's pain symptoms. Guidelines and References used: Official Disability Guidelines, Treatment Index, Fifth Edition 2008 (web) under Facet Joint Radiofrequency Neurotomy.

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 KNOWLEDGBASE
- 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)