COMPPARTNERS

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 06/09/08 **PATIENT NAME:**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the appropriateness of the previously denied request for right C4-5 and C5-6 facet and right suprascapular injections.

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

Texas licensed anesthesiologist.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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.

The previously denied request for right C4-5 and C5-6 facet and right suprascapular injections.

No guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY [SUMMARY]:
Age: xx years
Gender: Female
Date of Injury: xx/xx/xx
Mechanism of Injury: Repetitive motion.

Diagnosis: Cervical radiculitis, C5-6 disc-osteophyte complex, cervical facet syndrome and right suprascapular neuritis.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
This xx-year-old female sustained an industrial injury on xx/xx/xx. The mechanism of injury was repetitive motion while working as a . The current diagnosis is cervical radiculitis, C5-6 disc-osteophyte complex, cervical facet syndrome, and right suprascapular neuritis. An MRI of the cervical spine on 8/13/07, showed degenerative changes at the C5-6 level – a disc-osteophyte complex without evidence of cord or spinal nerve compression. An electromyogram (EMG) dated 9/21/07, showed evidence of right C6 nerve irritation (radiculitis) and right ulnar nerve conduction delay. The patient was noted to complain of pain in the "cervical region, down the right arm and into the right hand at the 4th and 5th digits." A recent examination in February 2008, showed tenderness over the right C4-5 and C5-6 facet joints and the right suprascapular region, along with right triceps weakness. In April, an examination noted tenderness over the medial epidcondyle and ulnar distribution. The patient's complaints remained unchanged at that visit. Per ODG: "Criteria for the use of diagnostic blocks for facet nerve pain: 1. One set of diagnostic medial branch blocks is required with a response of ≥ 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally." In this case, the patient had an EMG which documented evidence of right C6 radiculitis and complaints of radicular pain in that arm. Therefore, in accordance with criteria #2 of the ODG, recommendation is for an adverse determination. Per ODG, trigger point injections are not recommended in the absence of myofascial pain. In the pain section of ODT, it states that these "are under study." Therefore, given the patient's diagnosis, this type of intervention in unproven and lacks clinical evidence for efficacy.

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
- X 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)