Medwork Independent Review
1217 Menomonie Street
Eau Claire, Wisconsin 54703
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
medworkiro@charterinternet.com
www.medwork.org

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Network (WCN)

DATE OF REVIEW: **05/22/2008**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
64626 x1 radiofrequency @ left cervical medial branch nerve and 64627 x6 additional levels of left cervical medial branch nerves and left 3rd occipital nerve and 00600 x1 & 77003 x1
03/05/2008

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:
Injured male worker back on XX/XX/XX involving the cervical spine secondary to being struck by a motorized vehicle. Subsequent to the injury, the claimant has undergone multiple diagnostic studies to include plain film x-rays, cervical MRIs, and cervical myelograms with post-myelogram CT scans. Claimant is currently employed at a furniture store working as a 45 hours per week without restrictions. Current medication management appears to consist of MS Contin 15 mg two tablets every eight hours; Lyrica 50 mg two q.h.s.; Darvocet N-100 up to three tablets a day for breakthrough pain; Skelaxin 800 mg three to five tablets per day; Nexium 40 mg one per day; and over-the-counter Percogesic up to three at bedtime for sleep. Claimant has reportedly undergone radiofrequency ablation procedures of the left-sided cervical medial branch nerves on two separate occasions, the first being in December 2005 with reportedly good pain relief until July of 2006. A second left-sided cervical medial branch rhizotomy procedure was performed in December of 2006 with initial improvement of 30 to 40% by January and 70% improvement noted in May of 2007. At this time, it appears that the patient had an exacerbation

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of his neck pain. Interestingly, of note, the patient's medication profile during the above time periods following the interventional pain management procedures had not changed. A designated doctor evaluation performed on March 3, 2008 by , M.D. reports that claimant's rhizotomies/injections as well as the use of his prescription medications help him with his pain. Her diagnosis of this patient's pain is degenerative disk disease/spondylosis cervical spine.

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

After reviewing the information submitted, the previous non-authorization of the above-requested interventional pain management procedures are upheld. It is the opinion of this reviewer that the previously performed rhizotomies did not have any significant long-term benefit in relationship to decreased medication intake, decreased pain, increase in function, and/or decrease in medication intake. Therefore, in accordance with ODG Guidelines, related to criteria for repeat cervical facet neurotomies, recommendation is for an adverse determination of upholding previous non-authorization. As stated above, there was no documentation following the previously performed rhizotomies to include decreased pain (VAS score), increase in function and/or decreased extensive medication profile. 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 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**

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- ☐ **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)**