



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

DATE OF REVIEW: 05/07/2008

AMENDED DATE: 05/08/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Radiofrequency cervical facet injections on right side & additional levels of radiofrequency cervical facet injections on the left side (C3 thru C7)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to Medwork 04/18/2008
2. Texas Dept of Insurance notice to URA of assignment of 04/18/2008
3. Confirmation of Receipt of a Request for a Review by an IRO 04/17/2008
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 03/04/2008
6. Argus Services Corporation DWC Pre-Authorization Report & Notification (appeal) 03/03/2008, 02/21/2008
7. Letter of Medical Necessity Dr. 04/02/2008
8. Follow up report Dr. 03/25/2008
9. Pain Institute fax cover sheet 02/26/2008
10. Follow up report Dr. 02/26/2008
11. Pain Institute fax cover for preauthorization 02/12/2008
12. OP report Dr. 02/04/2008
13. Follow up report Dr. 01/29/2008, 12/21/2007
14. Pain Institute letter to Dr. 12/13/2007



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15. Follow up note Dr. 11/20/2007
16. Pain Institute letter 11/14/2007
17. OP report Dr. 11/06/2007
18. Pain Institute letter 10/19/2007
19. Prescription 10/11/2007
20. Follow up report Dr. 07/10/2007
21. Pain Institute Dr. 02/15/2005
22. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Injured male worker on xx/xx/xx involving the cervical and lumbar spine secondary to a slip and fall type mechanism.

Current Diagnoses:

1. Status post cervical fusion.
2. Status post lumbar fusion.
3. Status post lumbar spinal cord stimulator placement.
4. Status post radiofrequency ablation cervical medial branch nerves bilaterally C-2 through C-6 levels (performed 2004).

Currently, the patient is complaining of chronic neck pain and episodic upper extremity numbness and tingling rated a BAS score of 6/10. Current medication management consists of methadone 10 mg one tablet four times a day, gabapentin 300 mg three times a day, tizanidine 4 mg one to two three times a day, Mobic 15 mg one tablet q.d., and Doxepin 50 mg one to two at bedtime. Reportedly, this claimant underwent radiofrequency ablation, bilateral cervical medial branch nerves of the C-2 through C-6 level which reportedly from the office visit of 02/15/05 note provided the patient with close to nine months of near complete pain/headache relief along with decreased need for medications (narcotic analgesics, muscle relaxants, and antiinflammatory medications). The requesting provider, Dr. wishes to repeat the rhizotomy type procedure in an effort to decrease patient's neck pain and increase his range of motion. Of note, Dr. has already performed on 02/04/08 radiofrequency thermal medial branch neurotomies of the left C-3 through C-7 levels with bilateral cervical facet joint injections C2-3 through C7-T1 levels and trigger point injections left interscapular area, all on 02/04/08 with reportedly 80% pain relief in the neck.

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

After a review of the information submitted, it is the opinion of this reviewer that the previously non-certification for the requested services in dispute be overturned. The recommendation is that certification be authorized for radiofrequency cervical facet injections on right side & additional levels of radiofrequency cervical facet injections on the left side (C3 thru C7).

From the information submitted, the requested pain management intervention has already been performed in 2004 with documented efficacy. This patient is most certainly an outlier to ODG Guidelines which recommend no more than two joint levels may be blocked at any one time. The patient's previous certification in 2004 is probably under ACOM Guidelines. The



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previously prolonged evidence of effectiveness obtained after the above requested intervention in 2004 was influential on this peer review's determination today. The above certified services are medically necessary and appropriate and will provide patient with substantial sustained pain relief.

Guidelines and References used:

1. Official Disability Guidelines, Treatment Index, Fifth Edition 2008 (web) under Cervical-Facet Joint Injections.
2. ACOM Guidelines, Second Edition, Chapter 12.
3. Guidelines outlined in the pain management text book entitled Interventional Pain Management, Second Edition, edited by Dr. Steven D. Waldman, Chapter 42 under Facet Block/Neurolysis.
4. Practice Guidelines First Edition 2004, Spinal Diagnostic and Treatment Procedures (ISIS) edited by Dr. M. Bogduk, M.D.

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**



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- 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)**