CORE 400 LLC

240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 24, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral Cervical Medial Branch Block, Repeat Cervical MRI, Repeat Bilateral Upper Extremity NCV

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

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.

The reviewer finds that medical necessity does not exist for Bilateral Cervical Medial Branch Block, Repeat Cervical MRI, Repeat Bilateral Upper Extremity NCV.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male injured while on the job when involved in a motor vehicle collision. The patient was a restrained driver in the collision. After the injury, the patient began to complain of pain in the neck, back, right arm and right shoulder. After the injury, the patient was evaluated in the ER. Radiographs were negative for fracture or dislocation. The patient was diagnosed with a strain/sprain of the shoulder and neck.
The patient was treated with at least 15 sessions of physical therapy. An MRI of the right shoulder was returned with some mild AC joint arthrosis and no evidence of a rotator cuff tear. The patient had an MRI of the cervical spine which revealed a minimal posterior bulge at C5-6 and a normal nerve conduction study of the upper extremities.

The patient was noted to have returned to work full-time and was placed at MMI on 09/09/04. The patient continued to complain of pain in January 2008. The patient had a right suprascapular nerve block from Dr.

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

The clinician has failed to demonstrate the medical necessity for a repeat cervical MRI, a repeat bilateral upper extremity NCV, and a bilateral cervical medial branch block. The most recent office visit in July 2008 revealed an essentially normal exam of the cervical region with no pain demonstrated, no evidence of cervical facet syndrome, and no evidence of radiculopathy noted. The previous MRI was essentially normal, apart from a small bulge at C5-6 with a previous nerve conduction study returned without abnormality. The patient does not meet ODG criteria for a repeat MRI. In addition, the Official Disability Guidelines do not recommend medial branch blocks in patients with no evidence of cervical facet syndrome, and a nerve conduction study is not recommend by the Official Disability Guidelines for patients with localized neck pain. The reviewer finds that medical necessity does not exist for Bilateral Cervical Medial Branch Block, Repeat Cervical MRI, Repeat Bilateral Upper Extremity NCV.

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)**