

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/11/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical RFTC Right C3-5, 64626, 64627 x 4 sessions

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/15/09, 10/28/09
ODG Guidelines and Treatment Guidelines
MD, 7/31/06, 9/28/06, 8/2/07, 10/2/07, 12/3/07, 2/4/08
MD, 9/12/06-11/16/09
IRO Notice of Decision
ODG-TWC, Neck and Upper Back
Treatment History, undated

PATIENT CLINICAL HISTORY SUMMARY

This is a male patient injured on xx/xx/xx, with a history of left sided neck pain. There is no mention in the records of right-sided neck pain. Physical exam is significant for a positive Spurling's sign on the left.

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

Per the ODG, a RFTC of cervical medial branches "requires a diagnosis of facet joint pain." It appears that a "right cervical FMNB C3/5" was performed on 6/12/06. These results are not documented. In addition, the patient's history and physical exam is not consistent with right-sided facet joint pain. The patient does not complain of pain on the right neck. Also, the exam is significant for a positive Spurling sign which is indicative of radiculopathy. Per the ODG, a facet mediated pain diagnosis should be "limited to patients with cervical pain that is non-radicular." Therefore, the requested procedure (Cervical RFTC Right C3-5, 64626,

64627 x 4 sessions) does not conform to the ODG criteria. The reviewer finds that medical necessity does not exist for Cervical RFTC Right C3-5, 64626, 64627 x 4 sessions.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)