

C-IRO Inc.

An Independent Review Organization
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DATE OF REVIEW:

Jun/05/2009

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Right C3-C6 RFTC (Radiofrequency Thermocoagulation)

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

MD, Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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

ODG Guidelines and Treatment Guidelines
Determination Letters, 4/7/09, 5/5/09
MD, 5/14/09, 4/21/08, 6/9/08, 8/26/08, 3/30/09

PATIENT CLINICAL HISTORY SUMMARY

This woman was injured in xx-xxxx. She underwent an anterior cervical fusion (C4/5) in 2007 and has ongoing neck pain and reported cervical radiculopathy. She had 3 days of relief after a C3-6 medial branch block in April 2008. An RFTC in July 2008 gave relief for 7 months before symptoms recurred. Dr. described improved quality of life in the records submitted for this review. The claimant has underlying degenerative changes post fusion in the cervical region. She had unrelated low back surgery in the past.

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

The ODG recommends a case-by-case decision regarding facet rhizotomy. The ODG described failed treatment when there is increased pain with cervical hyperextension and axial rotation that is loading the facet joints. Dr. described a positive Spurling sign and pain on neck extension. The ODG also describes failed treatment with prior history of back surgery as this lady had. However, the records indicate these are relative and not absolute contraindications. Dr. wants to inject 3 levels (C3-C6) while the ODG's criteria is limited to two joint levels. The ODG recognizes that repeat injections may be necessary at no sooner than 6 month intervals. It has been 7 months in this case. Records indicate this person had relief at the 3 levels for 7 months. Based on this reported benefit, the reviewer concurs with

the treating provider that there is a role for this repeat rhizotomy even with the questions and issues described. The reviewer finds that medical necessity exists for Right C3-C6 RFTC (Radiofrequency Thermocoagulation).

Criteria for use of cervical facet radiofrequency neurotomy

1. Treatment requires a diagnosis of facet joint pain. See Facet joint diagnostic blocks
2. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
3. No more than two joint levels are to be performed at one time (See Facet joint diagnostic blocks)
4. If different regions require neural blockade, these should be performed at intervals of not sooner than one week, and preferably 2 weeks for most blocks
5. There should be evidence of a formal plan of rehabilitation in addition to facet joint therapy
6. While repeat neurotomies may be required, they should not be required at an interval of less than 6 months from the first procedure. Duration of effect after the first neurotomy should be documented for at least 12 weeks at $\geq 50\%$ relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.

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)