

SENT VIA EMAIL OR FAX ON  
Jun/10/2010

**True Decisions Inc.**  
An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jun/07/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

1 occipital nerve block

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

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**

OD Guidelines

Denial Letters 4/15/10 and 4/26/10

International 2008, 2//6/10, 3/23/10/

Diagnostic 9/20/1999, 9/28/1999, 10/26/1999, 1/18/2000

X-Ray 7/29/09

Dr. 3/31/10 and 4/28/10

Dr. 7/15/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man who apparently had 4 cervical operations concluding with an anterior fusion in 1999. He has a dorsal column stimulator. He had no response to cervical injections, facet or epidurals per a prior reviewer. Dr. performed an independent exam in 2009. Dr. addressed his depression and pain in 3/10. This man has ongoing neck pain. The 2/16/10 note described neck pain going to the right 4/5 digits. A prior reviewer noted that he had an occipital nerve block on 2/23/10. He had local tenderness bilaterally over the bilateral cervical spine, the facet region and the trapezius muscle and the occipital nerves. Dr. requested a

GON on 3/23/10.

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

The IRO reviewer is not clear if he did or did not have a GONB in February. He was described as having neck pain then. The March note describes neck pain radiating to the head. The ODG feels the value is unproven. The effects are limited by the local anesthetic. There is no discussion in the ASIPP or APS guidelines. The physical exam described shows generalized posterior tenderness, not specifically at the greater occipital nerve. While the lack of documented benefit does not mean lack of benefit, not enough information was provided to justify the procedure as being medically necessary.

**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)