

Wren Systems

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:

Radiofrequency Left Cervical Injection with anesthesia, fluoroscopy

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

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

CMS, 3/29/10, 4/23/10

M.D. 5/3/10, 3/8/10

DO, 3/8/10

Workers Compensation Pre-Authorization Request, 3/22/10

Fax, 4/19/10

PATIENT CLINICAL HISTORY SUMMARY

Per the office visit note on xx/xx/xx, the patient complains of "pain in the neck on the left side that radiates down the left shoulder." On 3/8/10, it is noted that the patient "has been doing well after left cervical facet RF in January 2010. However, pain has gradually returned in the "past 1-2 weeks." The patient experienced approximately 8 to 9 weeks of relief. There is no mention as to what levels were involved with the RF or how much pain relief was obtained.

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

Per the Official Disability Guidelines, for a repeat RF to be considered appropriate the "duration of effect after the first neurotomy should be documented for at least 12 weeks at \geq 50% relief." As noted above, relief was only experienced for 8 to 9 weeks. The amount of pain relief from the initial RF is not mentioned in the records provided. The ODG states that

RF “should not be required at an interval of less than 6 months from the first procedure.” This request is being made no more than 3 months since the first RF. For these reasons, upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The reviewer finds that medical necessity does not exist for Radiofrequency Left Cervical Injection with anesthesia, fluoroscopy.

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)