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**Notice of Independent Review Decision
IRO REVIEWER REPORT – WCN**

DATE OF REVIEW: 03/30/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Diagnostic cervical facet injections on the right at C3-C4 and C4-C5

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

Board Certified in Orthopedic 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)

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.

Diagnostic cervical facet injections on the right at C3-C4 and C4-C5 – Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A letter of medical necessity from M.D. dated 03/07/XX

An MRI of the cervical spine interpreted by Dr. (no credentials were listed) dated 11/29/XX

An EMG/NCV study interpreted by M.D. dated 12/08/XX

A prescription for Soma from Dr. dated 12/08/XX

An evaluation with M.D. dated 12/15/XX

Evaluations with Dr. dated 12/23/XX, 02/03/XX, 02/14/XX, and 02/28/XX

A letter of non-certification, according to the Official Disability Guidelines (ODG), from D.O. dated 01/04/XX

A letter of non-certification, according to the ODG, from M.D. dated 02/25/XX

Letters of non-certification, according to the ODG, from insurance company dated 02/25/XX and 03/07/XX

A letter of non-certification, according to the ODG, from M.D. dated 03/04/XX

An IRO request from insurance company dated 03/17/XX

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 03/07/XX, Dr. requested monitored anesthesia. An MRI of the cervical spine interpreted by Dr. on 11/29/XX showed mild disc protrusions at C3-C4 and C4-C5. An

EMG/NCV study interpreted by Dr. on 12/08/XX showed bilateral left greater than right carpal tunnel syndrome. On 12/15/XX, Dr. recommended a pain management evaluation and work restrictions. On 12/23/XX, Dr. recommended cervical facet blocks with a possible cervical epidural steroid injection (ESI). On 02/14/XX, Dr. again recommended cervical facet blocks. On 02/25/XX, Dr. wrote a letter of non-authorization for cervical facet blocks. On 02/25/XX and 03/07/XX, there were letters of non-authorization from insurance company for cervical facet blocks. On 03/04/XX, Dr. also wrote a letter of non-authorization for the cervical facet blocks.

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

The patient has not completed the appropriate conservative treatment, which includes therapy, prior to proceeding with cervical facet injections. There is no documentation of physical therapy progress notes provided for review. Furthermore, the claimant has also not had a trial of anti-inflammatory medications for at least four to six weeks. There is also no objective documentation in regard to the patient's response to the treatment provided to him thus far. There is also no evidence that the facet joints are involved in the patient's pain syndrome. There are no objective anatomic abnormalities for which facet blocks would be useful. Since the patient does not meet the ODG criteria for facet blocks, they are not appropriate. Therefore, the requested diagnostic cervical facet injections on the right at C3-C4 and C4-C5 are neither reasonable nor necessary and the previous adverse determinations should be upheld.

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 KNOWLEDGBASE
- 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)