

SENT VIA EMAIL OR FAX ON
Jul/06/2011

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/05/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Cervical Radio Frequency Ablation C4-6 X 2

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

Board Certified 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

OD Guidelines

1. Cover sheet and working documents
2. Utilization review determination dated 05/17/11, 05/25/11
3. Progress note dated 05/12/11, 03/02/11, 01/26/11, 12/23/10, 10/25/10, 09/27/10, 08/19/10, 05/05/10, 04/07/10, 03/10/10, 07/19/10, 06/23/11
4. Operative report dated 04/22/11, 12/07/10, 07/27/10
5. History and physical examination dated 06/17/10, 02/10/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient fell into a hole that collapsed during a cave in. He experienced the abrupt onset of severe sharp neck and shoulder pain. Treatment to date includes ACDF at C6-7 in 2001; left C4-C6 medial branch blocks on 07/27/10; left cervical radiofrequency ablation C4-C6 on 12/07/10 with essentially complete resolution of his neck pain; right C4-C6 medial branch blocks on 04/22/11 with 100% pain relief. On physical examination there is palpable tenderness over the right C4-5

and C5-6 facet joints producing concordant pain.

Initial request for right cervical radiofrequency ablation C4-6 x 2 was non-certified on 05/17/11 noting that the reported benefit from medial branch blocks has not been supported by objective documentation of improvement in VAS score and function. There is no documentation of a formal plan of rehabilitation in addition to facet joint therapy. The denial was upheld on appeal dated 05/25/11 noting that failure of conservative measures is not documented. There is no indication that this will be used as an adjunct to ongoing treatment modalities aimed at functional restoration.

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

Based on the clinical information provided, the request for right cervical radiofrequency ablation C4-6 x 2 is not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no documentation that the patient has been unresponsive to conservative measures. The request is excessive as the Official Disability Guidelines support repeat radiofrequency ablation only with evidence of documented relief lasting at least 12 weeks. Given the current clinical data, the request is not indicated as medically necessary, and the two previous denials are upheld.

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)