

**INDEPENDENT REVIEWERS OF TEXAS, INC.**

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Notice of Independent Review Decision

**Date notice sent to all parties:**

December 3, 2012

**IRO CASE #:**

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

Reconsideration: Repeat Left Suprascapular RFA

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

Board Certified PM&R

Board Certified Pain Medicine

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

x Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. Clinical note dated 01/03/12
2. Clinical notes dated 01/10/12-08/30/12
3. Clinical notes dated 01/10/12-09/10/12
4. CT cervical spine dated 08/23/12
5. Electrodiagnostic studies dated 08/23/12
6. Procedure notes dated 08/03/12 and 09/14/12
7. Required medical evaluation dated 08/02/12
8. Physical therapy report dated 02/16/12
9. Prior reviews dated 09/07/12 and 09/17/12
10. Cover sheet and working documents

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained an injury on xx/xx/xx. The patient is status post left shoulder subacromial decompression and rotator cuff repair with distal clavicle resection and biceps tenodesis. The patient continued to report complaints of left shoulder and neck pain and was additionally seen on 01/10/12. At this visit the patient's physical examination revealed limited range of motion of cervical spine with positive Spurling's sign. Left upper extremity weakness was noted on shoulder extension and abduction. There were concerns regarding suprascapular neuritis versus nerve entrapment, and the patient was recommended for suprascapular blocks and cervical epidural steroid injections. Follow up on 06/14/12 indicated the patient underwent a prior left suprascapular radiofrequency ablation procedure. The patient reported significant improvement in her mid back pain. The patient continued to report pain in neck and left shoulder. Physical examination was relatively unchanged from 01/12 exam. The patient underwent prior epidural steroid injections in 07/12 and 08/12. These injections provided relief for patient's neck pain. Electrodiagnostic studies completed on 08/23/12 were essentially unremarkable. Follow up on 08/30/12 stated the patient continued to report occasional radiating pain in left upper extremity, neck pain and left shoulder pain. Physical examination again revealed limited range of motion of cervical spine with positive Spurling's test. Continued mild weakness on left shoulder extension and abduction was noted. The patient was recommended for repeat left suprascapular radiofrequency ablation procedure.

The request for repeat left suprascapular RFA was denied by utilization review on 09/07/12 as there was no documentation regarding specific functional improvement or decrease in pain medication usage to support repeat procedures.

The request was again denied by utilization review on 09/17/12 as there was no documentation to support the patient had any significant improvements following initial left suprascapular radiofrequency ablation to support repeat procedures.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The requested repeat left suprascapular radiofrequency ablation would not be supported as medically necessary at this time based on clinical documentation submitted for review. The patient's initial radiofrequency ablation procedure of left suprascapular nerve was performed in 05/12. Although the clinical documentation indicated the patient had some response to the procedure, it is unclear from clinical documentation provided to what extent it had significant functional improvement or ability to decrease pain medications for

at least 3 months following radiofrequency ablation. Given the clear lack of objective evidence to support the initial radiofrequency ablation was successful in addressing the patient's symptoms, repeat procedures would not be supported at this time.

## IRO REVIEWER REPORT TEMPLATE -WC

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### A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

**x MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**x ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

ODG Neck & Upper Back Chapter

#### **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.