

US Resolutions Inc.

An Independent Review Organization
3267 Bee Caves Rd, PMB 107-93
Austin, TX 78746
Phone: (361) 226-1976
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/29/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

right occipital nerve block under fluoroscopy

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

M.D., Board Certified Pain Medicine

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

Official Disability Guidelines

Coventry 12/28/11 and 01/17/12

Physical therapy evaluation dated 03/08/11

Clinic notes Dr. dated 11/29/11- 02/08/12

CT brain dated 05/19/11

Clinical records Dr. dated 05/02/11-10/17/11

MRI cervical spine dated 03/29/11

Physical therapy progress note 03/24/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. He was getting into a forklift and a heavy piece of machinery hit the top of his head. Since this time he has suffered neck pain. He was referred for MRI of cervical spine on 03/29/11, which notes loss of lordosis with central disc protrusion at C5-6, and mild central canal narrowing was noted. The claimant came under the care of Dr. . It is noted he has undergone approximately 20 sessions of physical therapy with partial resolution of pain. He reported sharp pain that basically starts in lateral aspect of his neck and tends to go up the back of his head. He reported turning his head will cause pain. He denies any radiation into upper extremities. He is noted to be exquisitely tender to palpation along facets at right. He did not have any pain in distribution of greater lesser occipital nerves, but had muscle spasm palpable in trapezius and posterior spine. The claimant was treated with additional oral medications and physical therapy. He is later reported to have findings involving greater and lesser occipital nerves. His treatment was delayed due to intervening bout of pancreatitis. The claimant was referred for CT of brain without contrast on 05/19/11. This study is unremarkable. He was then referred to Dr.. He is noted to have been seen by Dr. who recommended injections into his neck. He's noted to have disc protrusions at C5-6 C6-7 and

C4-5 with mild spinal stenosis. Dr. recommends doing a blind occipital nerve block and if this does not help he recommends having it performed under fluoroscopy. This block was performed at this visit on 11/29/11. When seen in follow-up on 12/20/11 he reports about two weeks of no pain and he subsequently began to develop recurrent pain. He requests to undergo injection of the greater occipital nerve.

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

This claimant sustained head trauma, which led to the development of a greater occipital neuralgia. The records clearly provide physical examination data to correlate with this. The claimant has no intracranial pathology. The claimant has undergone an extensive course of physical therapy. A blind occipital nerve block was performed and the claimant is noted to have received approximately two weeks worth of relief with the general injection. The reviewer finds there is sufficient clinical information to establish the efficacy of this treatment recommendation and therefore finds that right occipital nerve block under fluoroscopy is 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)