

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/11/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: destroy cerv/thor facet jnt

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is this reviewer's opinion that medical necessity for the request to destroy cerv/thor facet jnt has not been established

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
MRI of the cervical spine dated 02/07/13
Patient history, undated and unsigned
Independent medical evaluation dated 11/05/13
Operative report dated 04/10/12
Partial procedure report dated 06/12/12
Clinical report dated 12/13/12
Clinical report dated 01/25/13
Clinical report dated 02/22/13
Clinical report dated 03/18/13
Clinical report dated 04/15/13
Clinical report dated 05/13/13
Clinical report dated 06/10/13
Clinical report dated 07/08/13
Clinical report dated 07/29/13
Clinical report dated 08/05/13
Clinical report dated 08/26/13
Clinical report dated 09/23/13
Clinical report dated 10/21/13
Procedure report dated 10/30/13
Post-procedure pain diary dated 10/30/13
Clinical report dated 11/18/13
Clinical report dated 12/16/13
Clinical report dated 01/13/14
Appeal letter dated 01/12/14
Clinical report dated 02/10/14

Prior utilization reports dated 12/18/13 – 02/17/14

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury on xx/xx/xx when he caught his head in the door of a vehicle. The patient has been followed for a history of neck pain as well as associated headaches. The patient's prior conservative treatment did include chiropractic therapy as well as physical therapy. The patient is noted to have had previous medial branch blocks in the upper cervical spine in 2012. Prior medication use has included muscle relaxers as well as Hydrocodone for pain. The patient had recently been followed for continuing complaints in the cervical spine with limited range of motion.

The patient did undergo right medial branch blocks at the C5, C6, and C7 medial branch nerves on 10/30/13. The post-procedure diary indicated that the patient's pre-procedure pain was 4/10 on the VAS. 1-3 hours following the procedure, the patient's pain scores reduced to 2. By the evening of the procedure, the patient's pain scores had increased up to 8/10 on the VAS with pain the following day at 5-6/10 on the VAS. Follow up on 11/18/13 indicated that the patient had continuing neck pain rating 4/10 on the VAS which was aggravated by cold weather or damp weather. The patient denied any radicular type symptoms. On physical examination, there was decreased range of motion in the cervical spine with most pain elicited on neck extension. There was tenderness to palpation over the lower cervical facets from C5 to C7. No neurological deficits were identified. Given the response to medial branch blocks, the patient was recommended for a facet rhizotomy. No changes were noted on the 12/16/13 or 01/13/14 clinical reports. The last evaluation on 02/10/14 again indicated the patient had approximately 50% relief of symptoms following the medial branch blocks to the right from C5 to C7 performed in October of 2013. The patient's physical examination continued to demonstrate pain to palpation over the lower facet joints from C5 to C7 without evidence of neurological deficit.

The request for right sided facet rhizotomy procedures was non-certified by utilization review on 01/29/14 as there was a lack of documentation regarding functional improvement at least 12 weeks following repeat radiofrequency procedures.

The request was again non-certified by utilization review on 02/17/14 as there were prior radiofrequency procedures which did not provide relief for more than 12 weeks at more than 50% relief of symptoms.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: In this case, the patient underwent recent right sided medial branch blocks from C5 to C7 on 10/30/13. The patient is noted to have had previous medial branch blocks completed in 2012; however, these were done to the right from C2 to C4. Based on the prior utilization reports, the most recent request for radiofrequency ablation procedures was made on the basis of limited results from this 1st rhizotomy procedure. The current request for a rhizotomy has been based on the results from the right C5 to C7 medial branch blocks for which the patient reported approximately 50% improvement 1-4 hours after the procedures were performed. Based on guideline recommendations regarding facet rhizotomy, there should be evidence of a greater than 70% response to medial branch blocks to confirm facet pain at the targeted levels which could reasonably respond to rhizotomy. In this case, the patient only reported 50% response to medial branch blocks performed on 10/30/13. Therefore, the patient does not meet the threshold for diagnostic medial branch blocks as outlined by current evidence based guidelines. As the patient's response to the injections was less than 70% as recommended by guidelines, it is this reviewer's opinion that medical necessity for the request to destroy cerv/thor facet jnt has not been established. Therefore, the prior 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)