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DATE NOTICE SENT TO ALL PARTIES: Apr/12/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: cervical medial branch block C3, C4, C5 and C6 levels, on the right and left side, on two separate days

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO Board Certified Physical Medicine and Rehabilitation

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 the opinion of this reviewer that the request for cervical medial branch blocks C3, C4, C5 and C6 levels, on the right and left on two separate days is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: This patient is a male. On XX/XX/XX, an MRI of the cervical spine found a fusion at C4-5 and C5-6 levels, without spinal canal or neural foraminal stenosis at that level. The fusion was well incorporated at those levels. There was degenerative disease with annular bulging and spinal canal narrowing at C2-3, and a disc osteophyte complex more to left of midline at C3-4, with spinal canal stenosis and cord encroachment without definite myelopathy. There was moderate neural foraminal stenosis seen on the left at that level.

On XX/XX/XX, the patient was seen in clinic for complaints of neck pain. Past surgical history included surgery to the neck with an unspecified procedure. On exam, sensation was intact and reflexes were intact.

On XX/XX/XX, the patient turned to clinic. He again described neck pain. On exam deep tendon reflexes were intact and sensation was intact. On an unspecified date, a list of procedures was submitted indicating that medial branch blocks had been performed on XX/XX/XX, XX/XX/XX, XX/XX/XX, with radiofrequency ablations being performed on XX/XX/XX-XX/XX/XX

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a utilization review report noted the request for cervical medial branch block C3, C4, C5, and C6 bilaterally on two separate days was non-certified. The records indicate the patient had undergone a spinal fusion procedure at C4-5 and C5-6 levels, and the guidelines used, Official Disability Guidelines, does not support medial branch blocks at a level where a fusion had been performed. Therefore the request was non-certified.

On XX/XX/XX, a utilization review report for the requested cervical medial branch blocks C3,

C4, C5 C6 right and left on two separate occasions, again utilized Official Disability Guidelines neck chapter, and stated that lacking clarification as to the specific type and efficacy of previously provided injections, this request would not be supported as being medically necessary.

Official Disability Guidelines state that a facet block should not be performed in patients who have had a previous fusion at the proposed injection site.

It is the opinion of this reviewer that the request for cervical medial branch blocks C3, C4, C5 and C6 levels, on the right and left on two separate days is not medically necessary and 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)