

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

**DATE OF REVIEW:** 04/16/08

**IRO CASE #:**

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

CT-directed stereotaxic balloon microcompression of gasserian ganglion with cisternogram

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

The TMF physician reviewer is a board certified neurosurgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

**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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the CT-directed stereotaxic balloon microcompression of gasserian ganglion with cisternogram is medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Decision letter from – 01/16/08, 02/28/08

- Request form outpatient surgical intervention by Dr. – 01/11/08
- History and Physical by Dr. – 01/07/08
- Report of MRI of the brain – 08/03/07
- Patient progress notes by Dr. – 09/06/07 to 03/20/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he was struck by an exploding pressure spray to his right side. This resulted in severe right shoulder injury as well as facial injuries. The patient has undergone two surgeries to his right shoulder as well as facial reconstruction surgeries. The patient is being treated by pain management including the use of Neurotin and analgesics. In addition he has undergone a trigeminal nerved block that gave him some increased hyper irritability of the nerve.

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

The proposed surgery is a reasonable treatment option and is medically appropriate in the clinical setting described. Both typical and atypical trigeminal neuralgia can be difficult to successfully treat and the success rates of different treatment vary substantially. The Mayo Clinic website lists the proposed treatment as an option to treat this patient's condition. The article/references cited by the two orthopedic reviews of this case (each used the same) is a 2005 literature review from Italy and is unresponsive of the decision to deny treatment.

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

- ACOEM- AMERICAN 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)**  
Mayo Clinic Website