

True Decisions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 214-594-8608

DATE OF REVIEW: JUNE 16, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Intercostal nerve block and caudal epidural steroid injection

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

Doctor of Medicine (M.D.) Orthopedic Surgeon

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

OD Guidelines

Denial Letters 5/15/08 and 5/6/08

Medical Records from Dr. 5/28/08 and 4/23/08

HEALTH AND WC NETWORK CERTIFICATION & QA 7/2/2008

IRO Decision/Report Template- WC

Medical Records from Dr. 4/7/05 thru 4/23/07
Medical Records from Dr. 2/25/04 thru 3/26/07
Medical Records from Dr. 4/11/05
CT Scan 6/6/07
CT Scan Lumbar Spine 7/30/03
Limited CT Scan 2/26/07
CT Myelogram 3/31/04
Thoracic & Lumbar Myelogram 3/31/04
MRI's: 6/20/03, 2/20/04, 10/27/06, 7/12/07, 7/13/07
Letter 6/5/08
Record from Dr. 1/20/06
Review Med 11/17/06

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient suffers from chronic pain after a thoracic discectomy and fusion. She also has lumbosacral radiculitis. She has failed conservative treatment and continues to have severe symptoms.

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

The intercostal injection would be helpful as a diagnostic and therapeutic maneuver, as would the caudal epidural block. As stated above, the patient suffers from chronic pain after a thoracic discectomy and fusion. She also has lumbosacral radiculitis. She has failed conservative treatment and continues to have severe symptoms. Therefore, the requested procedures are reasonable and medically necessary.

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)**