

Notice of Independent Review Decision

DATE OF REVIEW: 10/27/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection, anesthetic agent; other peripheral nerve or branch

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

The TMF physician reviewer is the same specialty as the treating doctor and is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician reviewer is in active practice and is familiar with the treatment or proposed treatment.

It is determined that the injection, anesthetic agent; other peripheral nerve or branch is not medically necessary to treat this patient's condition.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 10/13/09
- Determination letter – 09/22/09, 10/08/09, 10/12/09
- Office visit notes by Dr. – 07/23/09 to 09/04/09
- History & Physical by Dr. – 07/06/09
- Report of MRI of the lumbar spine – 11/03/08
- Letter to TMF – 10/14/09
- Initial prospective – 08/26/09, 09/22/09
- Appeal prospective – 10/08/09
- Preauthorization request from Dr. – no date
- History & Physical examination by Dr. – 12/15/08
- Functional Abilities Evaluation – 06/30/09
- Peer Review Report – 07/23/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was stacking ceramic tile resulting in back pain radiating into the right lower extremity to mid thigh. No neurological abnormalities have been documented on a number of physical examinations. An MRI of the lumbar spine performed on 11/03/08 revealed degenerative disc disease with disc protrusions at multiple levels. The treating physician is recommending that the patient undergo selective nerve blocks.

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

This patient has a diagnosis of lumbago. There are no physical findings to suggest that there is a radiculopathy present. The ODG criteria require the presence of a radiculopathy to justify the performance of epidural steroid injections or selective nerve branch block. Therefore, the medical necessity for the performance of selective nerve root blocks has not been established.

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)