

SENT VIA EMAIL OR FAX ON
Jun/28/2010

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral T11, T12, L1 MBB with IV sedation contrast and Fluoro

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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 5/19/10 and 6/1/10
Reconsideration Request 5/20/10
Pre-Cert Request 5/14/10
Integrity Pain 5/12/10 and 5/19/10
MRI 11/2/09

PATIENT CLINICAL HISTORY SUMMARY

This man was injured xx/xx/xx when he sustained compression fractures at T12 and L2. He underwent vertebroplasty in 11/3/09 at these levels. He reportedly has ongoing back pain. The only examination provided describes reduced lumbar motion with pain on hyperextension, and local tenderness at the facet regions from T12 to L2. There was reportedly right-sided positive SLR (tension sign) and reduced sensation in the left L4/5 region. Ms stated Dr. wants to proceed with a median branch (facet) block.

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

The first issue is whether there is facet pain. This requires a diagnostic block for confirmation. The ODG requires local tenderness. There is a required normal sensory exam and no evidence of a radiculopathy or positive SLR. While the latter are in question per Ms. Troyer's report, the sensory exam and the positive SLR/root tension signs are applicable to lower and not upper lumbar issues. Hence, the upper facet origin of the pain has not been discounted by findings about the lower roots.

The ODG discusses both diagnostic and therapeutic blocks. Diagnostic blocks are considered when a neurotomy may be considered later. MBB is preferred to intraarticular injections. The ODG is limited to 2 levels, which falls into the 3 roots discussed. Based upon the limited information provided, the IRO Reviewer cannot exclude facet pain as being present. The confirmation requires a trial of a diagnostic block, and these were requested. The procedure is medically necessary.

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)