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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/10/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right and Left Medial Branch Blocks C6, C7, T1

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

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

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 12/11/09, 12/18/09
Pain Consultants 12/7/09, 11/2/09

PATIENT CLINICAL HISTORY SUMMARY

The patient complains of neck pain that radiates to the bilateral shoulders, bilateral radial aspect of the arm, and into the bilateral hands status post a MVA. EMG/NCV shows that the patient has CTS. The OV note from 12/7/09 states that the patient "has not had any injections since last OV." The type of injection from the past is not specified in the records provided.

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

The records provided for this review do not specify what types of previous injections were performed and what results were obtained. The request does not meet guidelines. In addition, the request of a C6, C7, and T1 MBB would effectively numb the C6-C7 facet joint only. It is unclear from the records why performing a T1 MBB without a C8 or T2 MBB would be medically necessary. Per the ODG, cervical MBB's are "limited to patients with cervical pain that is non-radicular." Even though the patient has been diagnosed with CTS, the records are unclear regarding CTS accounting for the radicular symptoms in the arm. The reviewer finds that medical necessity does not exist for Right and Left Medial Branch Blocks C6, C7, T1.

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)