MEDRx

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Notice of Independent Review Decision

DATE OF REVIEW: 10/5/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a monitored anesthesia care by on-call certified nurse anesthetist.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a monitored anesthesia care by on-call certified nurse anesthetist.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:, and.

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from: 8/25/10 office note by MD, operative note 8/6/09, 7/17/09 lumbar MRI report, office notes by, MD from 7/6/09 to 8/6/10 and referral form of 8/9/10.

: precert request 8/10/10, 8/13/10 denial letter, 9/14/10 letter by, partial ODG guideline, 7/22/09 precert request, various HICFA 1500 forms, 9/7/10 denial letter and 9/7/10 Concentra report by DO.

:9/23/10 letter by, pre-op assessment and anesthesia record from Hospital
8/6/09, 8/20/09 report by BSD and a report by MD of 8/13/10.

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured at work on xx/xx/xx. A lumbar MRI on 7/17/09 revealed L3-4 mild DDD, moderate left foraminal and right foraminal stenosis at L4-5, and HNP posterocentrally at L5-S1 with mild bilateral foraminal stenosis.

He has been managed with lumbar TFESI at L3-4, L4-5, L5-S1, and S1 foramen under fluoroscopic guidance on 8/6/09. The patient became symptomatic again on 8/6/10. He failed to respond to oral corticosteroids. A repeat ESI has been proposed. This procedure is not being disputed; however, the utilization of a nurse anesthetist is being disputed.

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

A review of the ODG does not indicate the clinical implications for the use of an anesthetist for lumbar ESI. However, it does recommend ESI's as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, although ESIs have not been found to be as beneficial a treatment for the latter condition. *Use for chronic pain:* Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. The ideal time of either when to initiate treatment or when treatment is no longer thought to be effective has not been determined. Indications for repeating ESIs in patients with chronic pain at a level previously injected (> 24 months) include a symptom-free interval or indication of a new clinical presentation at the level.

For some patients, IV sedation will be required when performing lumbar ESI. However, a review of Vitals.com indicates that Dr. is an anesthesiologist with subspecialty in Pain Medicine. The reviewer opines that since an anesthesiologist will be performing the procedure, it not clear why the ulitilization of a nurse anesthetist will be required. The requestor did not provide any clear rationale for the nurse anesthetists' presence during the procedure; therefore, it is found to be not medically necessary at this time.

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)**