

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 04/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient left C3-C4, C4-C5 medial branch block with conscious sedation

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

The TMF physician reviewer is board certified in pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the outpatient left C3-C4, C4-C5 medial branch block with conscious sedation is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 03/28/11

- Decision letter. – 02/03/11, 03/25/11
- Preauthorization request from Dr. – 01/27/11
- Patient face sheet from Dr. – 01/17/11
- Progress notes by Dr. – 04/19/10 to 01/17/11
- History and Physical by Dr. – 07/28/09
- Needle electromyography and nerve conduction studies report – 08/12/09
- Initial outpatient comprehensive visit by Dr. – 02/23/10
- Procedure note by Dr. – 04/08/10, 05/20/10
- Report of motor and sensory nerve study – 03/30/10
- Report of MRI of the right shoulder – 01/13/10
- Report of MRI of the cervical spine, lumbar spine – 03/12/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he was involved in an accident. This resulted in injury to the spine from the mid cervical area radiating down both scapula and deltoid. He also complains of lower back pain radiating to both legs associated with bilateral hip flexor weakness. The patient has been treated with physical therapy, muscle stimulator and transforaminal epidural steroid injections to the nerve roots at left L4 and Left L5. There is a request for outpatient left C3-C4, C4-C5 medial branch block with conscious sedation.

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

This patient is experiencing neck pain following an injury and conservative measures have failed. There is no radiculopathy, the EMG is normal and there is no deficit. The medical record documentation indicates pain in the left neck with radiation to the scapula and non-radicular. There are definite facet related symptoms such as localized pain that is worse with loading of the facets. Conservative measures have failed and MRI findings are not required by the ODG. ODG criteria have been met.

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)