

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 05/09/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical nerve root block on the right, C4/C5, C5/C6, and C6/C7

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in private practice of Pain Management full time since 1993

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Medical necessity has not been demonstrated for the requested nerve root blocks.

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
724.2	64490		Prosp.				04/29/10		Upheld
724.4	64481		Prosp.				04/29/10		Upheld
784.0	77003		Prosp.				04/29/10		Upheld

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment.
2. Letters of denial 03/09/11 & 04/07/11, including criteria used in the denial.
3. Pain management consultation reports 01/03, 11/15, 12/13/2010 & 01/31, 02/28, 03/28/2011.
4. Lumbar spine MRI 08/18/10

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The history is convoluted because the notes are difficult to decipher since there are numerous sites of pain. Intermittently there is pain described in the right forearm, left forearm, shoulder, cervical spine, and low back. A lumbar MRI scan is noted in the chart. There is mention that cervical facet injections were performed in office. If this is a true statement, then ODG have not been followed since there is no mention that fluoroscopy was utilized. The cervical

spine x-ray was reportedly unremarkable. Ten sessions of a chronic pain management program have been provided. There is mention that grip strength on the right is decreased. No cervical MRI scan is included in the records and no EMG.

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

ODG require evidence of radiculopathy in correlation of radiculopathic findings with MRI scan findings. No MRI scan has been presented. The only evidence of radiculopathy is decreased grip strength. ODG stipulate a maximum of two transforaminal injections; three are requested. ODG are not met due to the lack of documentation of radiculopathy and excessive number of levels requested.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)