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Notice of Independent Review Decision

DATE OF REVIEW: September 8, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left psoas compartment plexus block under fluoroscopy. CPT Codes: 64450, 77003, 99144, 64450 and 77003.

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

DIPLOMATE, AMERICAN BOARD OF ANESTHESIOLOGY
DIPLOMATE, AMERICAN ACADEMY OF PAIN MANAGEMENT

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

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- M.D., 07/21/11, 07/25/11
- Solutions, 08/01/11, 08/15/11
- 04/05/10
- CMS, 08/25/11

Medical records from the Provider include:

- M.D., 12/18/06, 06/28/07, 11/04/09, 11/12/09, 12/02/09, 05/06/10, 12/28/10, 04/07/11, 04/26/11, 05/18/10, 05/26/11, 07/21/11
- Physical Rehabilitation, 07/09/07, 07/10/07, 07/12/07
- Texas Workers' Compensation Work Status Report, 06/16/09
- Hospital, 04/01/11

- Pain Institute, no date

PATIENT CLINICAL HISTORY:

Description of Services in Dispute: Left psoas compartment plexus block under fluoroscopy guidance. The CPT codes include: 64450, 77003, 99144, 64450, and 77003.

Review Outcome: Upheld previous non-authorization.

Guidelines References Used: No references to this type of injection either in the current ODG Guidelines, ACOEM Guidelines or pain management textbook entitled *Interventional Pain Management*, Second Edition, and Edited by Dr.

This is a patient with a history of low back pain and injury since xx/xx/xxxx.

The patient's most recent assessment dated July 21, 2011, includes: 1) Patient with a history of lower back pain with left-sided radiculitis, with an acute exacerbation; 2) status post lumbar spinal cord stimulator placement. The patient is complaining of low back pain with radiation down the left lower extremity. The patient reports giveaway strength with ambulation. It is noted the patient has fallen on two occasions. The clinical examination reveals reproducible trigger point tenderness noted to the quadratus lumborum, gluteus medius, and gluteus maximus on the left. The iliopsoas is positive on the left (this structure is a muscle, not a diagnostic physical exam test).

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

After reviewing the information submitted, the previous non-authorization for left psoas compartment plexus block under fluoroscopy has been upheld. It is not clear to the reviewer whether this injection is related and how it is related to the patient's pain generator. It is not clear to the reviewer how this injection will improve the patient's overall function. The submitted interventional pain management injections performed in the past has resulted in unsustained relief. What is clear to the reviewer is the patient has recently been having issues with the spinal cord stimulator function.

As stated above, there are no references to this specific block in the ODG/ACOEM and/or individual pain management textbook.

Of note: There was no appeal letter generated by the requesting provider indicating the rationale for the procedure.

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)