

SENT VIA EMAIL OR FAX ON
Jan/27/2012

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/26/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right medial branch block T7, T8, T9 with sedation, contrast and fluroscopy

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

Anesthesiology/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

OD Guidelines

Texas Outpatient Voluntary non-certification recommendation 12/12/11

Outpatient reconsideration decision non-certification 01/09/12

Preauthorization request 12/19/11

MRI thoracic spine 10/12/11

Pain management consultation M.D. 12/14/11

Preauthorization request / letter of reconsideration 12/28/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. Per pain management consultation report dated 12/14/11 the claimant was unloading the patient's wheelchair when another person let go of wheelchair and rolled towards him hitting him on left leg and twisted his back. The patient was treated initially with medications and physical therapy. He had x-rays and went to pain management clinic and given more medications and Prednisone pack. The

claimant appears to have also had chiropractic therapy. MRI of thoracic spine performed on 10/12/11 reported facet arthrosis causing mild to moderate bilateral neural foraminal narrowing at T8-9. There is no HNP, canal stenosis, or significant neural foraminal narrowing identified. Musculoskeletal examination performed 12/14/11 reported pain on palpation mid back at T7-8 and T8-9 facet joints on right. In the low back he had no pain with range of motion and no pain on palpation. Reflexes were 2+ bilaterally, neurosensory testing was within normal limits, motor strength testing was 5/5 bilaterally. Straight leg raise was negative for radiculopathy bilaterally, shear compression test was negative bilaterally, and Patrick's test was negative bilaterally. The patient was recommended to undergo medial branch block on right at T7, T8 and T9.

A request for right medial branch blocks at T7, T8 and T9 with IV sedation, contrast and fluoroscopy was reviewed on 12/22/11 and non-certified as medically necessary. The reviewer noted current clinical guidelines report medial branch blocks/facet injections are not recommended. There is clinical research on therapeutic blocks and neurotomy in this region, and latter procedures (neurotomies) are not recommended. Recent publications on the topic have not addressed the use of therapeutic facet injections for thoracic region. Pain due to facet joint arthrosis is less common in thoracic areas. There is overall less movement due to attachment of rib cage. Injections of joints in this region also present technical challenge. Based on the clinical information provided can current clinical guidelines, the request of medial branch blocks at T7, T8, and T9 with IV sedation, contrast and fluoroscopy are not considered to be reasonable or medically necessary.

A request for reconsideration of non-certification recommendation was reviewed on 01/09/10, and the request was non-certified as medically necessary. It was noted the claimant was evaluated, x-rayed, medicated and referred to physical therapy. He has also been provided chiropractic therapy, the outcome of which and duration is not reported in available medical documentation. The claimant complains of right sided mid back pain and tailbone pain with radiation into right hip. Physical examination showed pain on palpation at T7-8 and T8-9 facet regions on right. There is no low back pain with range of motion or palpation. Reflexes are symmetric and equal bilaterally. Neurosensory testing is within normal limits and motor strength is 5/5. Straight leg raise is negative. MRI reported facet arthrosis was mild to moderate bilateral neural foraminal narrowing and at T8-9. The reviewer noted the claimant has persistent right sided paravertebral somatic complaints for which trial for diagnostic medial branch blocks has been requested. The claimant has received physical medicine services via chiropractic treatment suggesting manual medicine techniques have been employed. Pain levels remain elevated at 5-7/10 and claimant was reported to be taking no medications; however, Naprosyn, Soma and Fioricet have been prescribed on prn basis. Clinical guidelines do not support performance of thoracic spine medial branch blocks or radiofrequency neurotomy, hence medical necessity for proposed procedure is not established at this time.

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

Based on the clinical information provided, the request for right medial branch block T7-8-9 with sedation, contrast and fluoroscopy is not supported as medically necessary. The claimant is noted to have sustained injury on xx/xx. He complained of pain in right mid back area. The claimant was treated conservatively with physical therapy for 2-3 weeks and had medication management including muscle relaxants, Medrol DosePak and nonsteroidal anti-inflammatories. Physical examination reported pain on palpation at T7-8 and T8-9 facet joints on right. Per ODG guidelines, thoracic facet joint injections are not recommended due to limited research on therapeutic blocks or neurotomies in thoracic region. Guidelines note pain due to facet arthrosis is less common in thoracic area as there is overall less movement due to attachment of rib cage. Furthermore, injection in this region is technically challenging. As such, medical necessity is not established for proposed medial branch blocks, and previous denials should be upheld on IRO.

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)