

Notice of Independent Review Decision

DATE OF REVIEW: 04/24/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar facet injection w/fluoroscopy and IV sedation 64493 64494 64495

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 anesthesia and 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 lumbar facet injection w/fluoroscopy and IV sedation 64493 64494 64495 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 04/11/13
- Letter of Determination – 03/14/13, 04/03/13
- Complete Rationale for Denial of Preauthorization 03/13/13
- Complete Rationale for Denial of Preauthorization – 04/02/13
- Preauthorization Request Form – no date
- Follow up office notes – 11/28/12 to 03/27/13

- Operative Report – 12/05/12, 01/16/13
- Initial Pain Evaluation – 11/07/12
- Results of MRI of the lumbar spine – 02/28/12
- Radiology report of x-rays of the back – 07/27/12
- Radiology report of x-rays of the lumbar spine – 02/09/12
- Operative Report – 03/28/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he was bending over, picking up a heavy object and twisting. This resulted in sharp pain that was constant for several months. The patient has undergone chiropractic manipulations, physical therapy, epidural steroid injections and eventually surgery. The patient has long-term radicular pain due to gait changes and there is a recommendation for the patient to undergo lumbar facet injection w/fluoroscopy and IV sedation 64493 64494 64495.

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

The medical record documentation states that the patient's back pain is the primary site of her pain and radicular pain is minor. There has been failure of conservative measures. Although intravenous sedation is discouraged, the treating physician states that only Propofol will be administered. The ODG does allow for sedation if anxiety is present and the treating physician indicates that the injured worker cannot lie prone due to nerve pain. Therefore, it is determined that the ODG are met for the procedure and sedation as requested.

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)