



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
Phone: 214 732 9359 | Fax: 972 980 7836

**DATE OF REVIEW:** 12/31/2018

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

“XXXX Stellate XX block, under Fluoroscopy with IV sedation” for the patient.

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

D.O. Board Certified in 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)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

XXXX. Patient is complaining of XXXX hand and arm pain, XXXX thumb De XX XX, XX, XX with associated pain on passive ROM. Patient did report XX% plus relief from previous XX XX block with reported improve ROM and decrease use of medication. Presently patient is on XXXX. On XXXX physician reported decrease XXXX grip strength with all other symptoms reported above and recommended XXXX stellate and to be followed with rehab. On last visit dated XXXX the patient’s symptoms were getting worse with need to increase pain meds; again XXXX Physician is recommending a stellate XX block.

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

Per ODG references, the requested “XXXX Stellate XX block, under Fluoroscopy with IV sedation” is medically necessary. Patient’s symptoms as described by XXXX physician do meet the Budapest (Hardin) Criteria. Patient exhausted conservative treatment and had a successful treatment with stellate XX block resulting in over XX% pain relief and decreased usage of pain meds. XXXX physician is recommending rehab after the block. Therefore, a XXXX Stellate XX block, under fluoroscopy with IV sedation, is certifiable.



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**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 KNOWLEDGE BASE
- 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