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Notice of Independent Review Decision

DATE OF REVIEW: October 29, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CPT Code 64520 – Nerve block, lumbar/thoracic

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 URA include:

- Official Disability Guidelines, 2007
- M.D., 07/03/07
- 07/11/07, 08/22/07, 09/28/07, 10/10/07
- M.D., 07/18/07, 07/26/07, 08/21/07, 10/22/07, 08/29/07, 09/04/07
- 07/18/07, 07/26/07, 08/29/07
- M.D., 08/15/07
- 08/21/07

Medical records from the Provider include:

- Pain Institute, M.D., 12/29/05, 04/25/06, 04/24/07, 05/15/07, 05/22/07, 06/26/07, 08/21/07, 09/25/07

- Radiology, M.D., 01/21/07
- System, 04/26/07
- M.D., 04/25/07

PATIENT CLINICAL HISTORY:

Male worker injured on xx/xx/xx, involving the lumbar spine. Mechanism of injury not documented. Current diagnosis: Chronic right foot/ankle pain and complex regional pain syndrome (CRPS) right lower extremity.

Subsequent to the patient's injury, he was diagnosed with a complex regional pain syndrome right lower extremity. Completed treatment regarding this diagnosis involves multiple lumbar sympathetic blocks in 2001, followed up with lumbar spinal cord stimulator placement of which there has been a replacement of battery and leads. From the follow up note dated June 26, 2007, the spinal cord stimulator system was analyzed in the office and reported to be functioning appropriately. The system indicated a use of 100%. Of note, physical examination reported right foot warm and dry with hypersensitivity to light touch in the medial aspect of the foot. Range of motion of the right foot and ankle limited with pain.

Subsequent to this, the patient underwent two additional right lumbar sympathetic nerve blocks and recently, within the past two months, underwent a right lumbar sympathetic neurolytic block with Phenol. From a follow up note dated September 25, 2006, the patient reported significant relief of his neuropathic pain to the right foot and ankle; however, he now has new onset of neuropathic burning pain to the right anterior groin and anterior thigh. The patient was going to be tried on analgesics, antiseizure medication (Neurontin), and TENS unit application for the above new symptom. If unsuccessful, requesting provider was going to proceed with repeat lumbar sympathetic nerve block without a Phenol agent.

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

After review of the information provided, the recent denial for additional lumbar sympathetic nerve blocks is upheld. It appears the patient has new onset of burning type pain in the anterior right groin/thigh, which was not in consideration with the previous lumbar sympathetic nerve blocks. There is no clear determination whether this pain is sympathetically mediated or not. The requesting provider has not determined a medical necessity/rationale for the requested intervention.

**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)