

SENT VIA EMAIL OR FAX ON
Dec/03/2009

Pure Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Myelogram with CT Scan and Right S1 Transforaminal Selective Nerve Root Injection

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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)

The lumbar myelogram with CT is medically necessary.

The selective nerve root block at S1 is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 9/22/09 and 9/25/09

Dr. 9/1/09

Dr. clinic note 09/14/2009

Records from the URA 243 pages from 6/2008 thru 11/2009

Dr. clinic notes 11/25/2008, 01/13/2009, 01/20/2009, 02/24/2009, 05/12/2009, 08/11/2009

MRI of the lumbar spine reports 07/10/2008, 04/21/2009

Radiology 1/05/09 and 7/10/08

OP Reports 7/10/09 and 1/5/09

Radiography Note 7/10/09

Dr. 5/22/09

7/9/08, 07/11/2008, 10/15/2008
Intraoperative monitoring report 01/05/2009

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a date of injury xx/xx/xx. He complains of low back pain radiating to the right lower extremity, right lateral thigh and lateral aspect of right toe. His leg pain is greater than his back pain. Recently, he has had some transient numbness into the left foot. On 01/05/2009 he underwent an L5-S1 discectomy on the right, without improvement. He has had epidural steroid injections. . He recently underwent a right L5 selective nerve root block on 07/10/2009 with no improvement. His neurological examination reveals slight weakness with right ankle eversion and diminished right patellar reflex, and trace ankle bilaterally. An EMG 05/22/2009 was negative for radiculopathy. An MRI of the lumbar spine 04/21/2009 shows postoperative changes at L5-S1, and disc bulging at L4-L5 with effacement of the thecal sac. The provider believes the MRI shows some contact with the right L5 nerve root at this level, as well. The request is for a Lumbar myelogram with CT Scan and right S1 transforaminal selective nerve root injection.

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

The lumbar myelogram with CT is medically necessary. According to the ODG, "Low Back" chapter, a myelogram is indicated if the MRI is inconclusive. The provider believes that there is contact of the L5 nerve root seen on MRI, and on examination, the claimant has evidence of an L4-L5 radiculopathy. Therefore, a CT myelogram would be appropriate to better analyze the lower lumbar spine and to ascertain if there is, indeed, compromise of the L5 nerve root.

The selective nerve root block at S1 is not medically necessary. According to the ODG, "Low Back" chapter, diagnostic epidural steroid injections are indicated to determine the level of radicular pain when diagnostic or clinical findings are inconclusive. The claimant has no evidence of an S1 radiculopathy on examination and does not have any apparent S1 nerve root compression by neuroimaging. There is nothing about S1 involvement in the clinical picture that appears inconclusive. Therefore, the selective S1 nerve root block is not medically necessary.

References/Guidelines

2009 *Official Disability Guidelines*, 13th edition

"Low Back" chapter

Myelography/CT myelography: Not recommended except for indications below for CT. CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. ([Slebus, 1988](#)) ([Bigos, 1999](#)) ([ACR, 2000](#)) ([Airaksinen, 2006](#)) ([Chou, 2007](#))

Epidural Steroid Injections, diagnostic

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)