



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 9/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LUMBAR ESI AT LEFT L5-S1.
CPT 64483,64484,77003-26 AND 99144

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

M.D. Board Certified in Orthopedic Surgery/ Fellowship trained in Spine Surgery

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

Document Type	Date(s) Month/Day/Year
Notice of Case Assignment	8/29/2011
Preauthorization Determination: Adverse Determination	8/19/2011 7/27/2011
Medical Reviews Final Reports	7/27/2011-8/19/2011
Workers Comp Preauthorization Request Form	7/20/2011
Office Visit	6/23/2011



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Employee Counsel	8/12/2011
M.D.	6/23/2011
MRI Report	11/02/2010
Interpretation of Neurodiagnostic Test	12/07/2010

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male who injured his low back by picking up a dolly on xx/xx/xxxx and complained of low back pain radiating to the left leg. Notes dated 6/23/2011 indicate the injured worker described pain as an ache, deep, diffuse, discomforting, dull, localized, numbness, piercing, sharp, shooting, stabbing and throbbing. Symptoms are aggravated by bending and changing positions, coughing, jumping, sneezing, standing, twisting and walking. Symptoms are relieved by lying down.

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

The selective root blocks are not medically necessary. Rationale: Based on ODG guidelines the patient does not meet the criteria necessary to proceed with injections. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. In this case both the MRI and EMG studies were non corroborating with either an left L5 or S1 compression or radiculopathy. The MRI showed no evidence of any significant compression of the left L5 or S1 nerve root. The EMG was within normal limits. The objective findings included a positive straight leg raise clinical atrophy of the gastrocnemius and ankle dorsiflexors with an intact and symmetrical patella and Achilles tendon reflex. However, these findings in and of itself is insufficient to support medical necessity based on ODG guidelines.

References:

1. ODG Guidelines
2. Transforaminal ESIs in Lumbosacral Radiculopathy; Spine 1 January 2002; Vol 27 pp11-15
3. Efficacy of Steroid and Nonsteroid Caudal ESI injections for Low Back Pain and Sciatica: Spine; 15 June 2009; 34: pp1441-47.

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



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- 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: