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Notice of Independent Review Decision

DATE OF REVIEW: 2/28/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Selective Nerve Root Bilateral L5-S1 w/ Sedation 64483 72275 99144

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

The reviewer is a Medical Doctor who is board certified in Orthopedic 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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of Selective Nerve Root Bilateral L5-S1 w/ Sedation 64483 72275 99144

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

Texas Department of Insurance, These records consist of the following (duplicate records are only listed from one source): Records reviewed from Texas Department of Insurance

Texas Department of Insurance

Intake Paperwork

Denials- 1/22/13, 2/6/13

Records reviewed from
Clinic

Office Notes- 7/12/12, 8/16/12, 9/18/12, 11/29/12

Hospital

Orders- 11/17/12

Current Medications List- 11/17/12

Nursing Assessment- 11/17/12

Emergency Physician Record- 11/17/12

Physical Exam- 11/17/12

ER Trauma Record- 11/17/12

MRI Lumbar Spine- 9/30/08

Emergency Department

ER Note- 11/29/12

Office Notes- 1/14/13

Imaging

Radiology Report- 11/17/12

Records reviewed from

Scripts for Orders- 1/16/13

Injured Worker Information- 1/9/13

Hospital

MRI Cervical Spine- 4/25/12

MRI Lumbar Spine- 4/25/12

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was injured while working. He reportedly fell and a co-worker fell upon him. He has had persistent low back pain with radiation into the lower extremities, including paresthesias. The claimant is also most recently noted slight weakness of the bilateral tibial anterior muscles. A prior 4/25/12 dated lumbar MRI has been reported as degenerative changes with an old compression fracture minimal disc dessication overall. Electrical studies were noted to reveal L5 radiculopathy as of 8/16/12. On 11/29/12, the claimant was noted to have a CT scan revealing lumbar transverse process fractures at L2-3 and compression fracture, old at T12. On 1/14/13, the claimant was reported as being persistently symptomatic. The exam revealed a slow and purposeful gait, paravertebral muscle tenderness, decreased and painful lumbar motion and a positive left straight leg raise. Weakness of the tibialis anterior muscles bilaterally was noted. The MRI was reportedly noted to reveal mild nerve root contact at the level of S1 bilaterally. Treatment with therapy or injections was noted to have not occurred. Denial letters reiterated the lack of trial and failure of recent comprehensive non-operative treatment.

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

Recommend approval of requested services. The clinical findings of lower extremity weakness do not correlate with the radiologist's impression of the MRI or CT findings. The electrical findings do seem to correspond to the clinical findings of L5 radiculopathy. The claimant has been documented as having failed treatment with restricted activity and medications. ODG criteria supports selective nerve root blocks in which there is evidence of a radicular pain generator "when physical signs and symptoms differ from that found on imaging settings." Therefore the overall intent all the guideline criteria has been met and the request is medically reasonable and necessary at this time.

Reference: ODG Low Back Chapter

Selective Nerve Root Blocks: Recommended as indicated below. Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed as a diagnostic technique to determine the level of radicular pain. In studies evaluating the predictive value of selective nerve root blocks, only 5% of appropriate patients did not receive relief of pain with injections. No more than 2 levels of blocks should be performed on one day. The response to the local anesthetic is considered an important finding in determining nerve root pathology. ([CMS, 2004](#)) ([Benzon, 2005](#)) When used as a diagnostic technique a small volume of local is used (<1.0 ml) as greater volumes of injectate may spread to adjacent levels. When used for diagnostic purposes the following indications have been recommended:

- 1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:
- 2) To help to evaluate a radicular pain generator when physical signs and symptoms differ from that found on imaging studies;
- 3) To help to determine pain generators when there is evidence of multi-level nerve root compression;
- 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive;
- 5) To help to identify the origin of pain in patients who have had previous spinal surgery.

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)