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Notice of Independent Review Decision

March 23, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right T7-8 Selective Nerve Root Block to Include CPT Codes 64479, 77003-26

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Texas Licensed, Board Certified Orthopedic Surgeon

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant has been documented to be an approximate xx-year-old. The claimant was originally injured in xx of xxxx in a fall off of a ladder. Multiple diagnoses have included chronic pain, muscle spasms, thoracic paravertebral fracture, and degenerative disease of the thoracic and thoracolumbar discs. The claimant has been documented to be status post bilateral medial branch nerve rhizotomy in January of 2003 at T8-9. Diagnostic MRI from 07/29/2014 revealed Schmorl's node deformity at T3 and T8 and was otherwise unremarkable. The provider records were reviewed. Treatments have included multiple forms of

medication. In addition, the provider records have revealed that the claimant has undergone at least two prior epidural steroid injections/selective nerve root blocks most recently on 07/30. The subsequent records discussed a consideration for a posterior fusion from T7 to T8 with possibly till T9. That was noted on the follow up date of 08/13/2014. It was noted on 08/13/2014 that with regards to the recent injection "It really was not much in terms of long-term relief of symptoms…" The notes from 10/31/2014 reveal however that the patient had "proven relief of his symptoms with the selective nerve root block at T7-8 on two separate occasions." The subsequent records were from 10/21/2014 discussing thoracic tenderness at the mid thoracic spine that is and muscle spasm. The consideration was for the possible pre-certification of a discogram with impression added including "thoracic neuritis or radiculitis" among other findings. Multiple medications were reiterated also as being indicated. The provider's patient was further evaluated on February 11, 2015 with ongoing symptomatic back pain in particular. Denial letters discussed the lack of guideline associated positive response from prior injections and the lack of ongoing radiculopathy with imaging corroboration.

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

The most recent records do not evidence ongoing clinically objective radiculopathy as corroborated by electrodiagnostics and/or imaging studies. The records also do not evidence at least 50-70% pain reduction and/or functionality improvement for a 6 to 8-week period from prior epidural injection selective nerve root block. Therefore, at this time, the referenced ODG guidelines with regards to the thoracic and lumbar spine and indications for selective nerve root block/epidural steroid injections have not been met. Therefore, the considered request is not medically reasonable or necessary at this time as it does not meet the applicable guidelines referenced below.

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)**