

CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: April 9, 2012

IRO CASE #: 39888

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Selective nerve root injection left L3-4, L4-5

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

This physician is Board Certified by American Board of Orthopedic Surgeons with over 40 years of experience.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

02/10/12: MRI Lumbar Spine without Contrast interpreted by
02/15/12: Follow-up Evaluation by
02/27/12: Consultation with
02/27/12: Lumbar X-rays, AP flexion/extension interpreted by
03/05/12: UR performed by
03/14/12: UR performed by
03/19/12: Follow-up Evaluation with

PATIENT CLINICAL HISTORY [SUMMARY]:

On January 14, 2012, the male fell off of a truck and developed severe lumbar and left leg pain. He does have a prior surgical history of back surgery at L4-5 in 1997.

On February 10, 12, MRI of the lumbar spine without contrast: Impression: 1. Sequela of left laminectomy at L4/5 with wide patency of the spinal canal. Underlying disc bulge results in right subarticular recess narrowing and moderate bilateral neural foraminal stenosis at this level. 2. Small far left lateral disc protrusion at L3/4 with contact of the extraforaminal left L3 nerve. 3. Small left foraminal/extraforaminal disc protrusion and peridiscal inflammation at L2/3 with contact and mild displacement of the exiting left L2 nerve. 4. Unilateral right L5 pars interarticularis defect without anterolisthesis.

On February 15, 2012, the claimant had a follow-up evaluation with who reported his pain level as 7/10. The pain was described as burning, sharp and worse after activity. The pain was located on lower back, lumbar region, and left leg and groin area. He also had complaints of associated numbness of the left leg. On physical examination there was a scar from a previous surgery. SLR was positive on the left and there was hypersensitivity to touch the skin of the left lower leg. He had a normal gait. No spinous tenderness. There was decreased lumbar ROM and there was tenderness to palpation of the left groin area. Diagnosis: 1. Lumbar radiculopathy. 2. Lumbar strain. 3. Groin strain. 4. Back contusion. Plan: Refer to orthopedic spine surgeon for further evaluation. He was also prescribed Norco 5/325 and placed on restricted activities.

On February 27, 2012, the claimant was evaluated by who reported continued pain that radiated into the left groin as well as to the lateral aspect of the left thigh. On physical examination, he had groin pain. He had difficulty stepping up on a step and had left quad weakness. The left quadriceps was rated about 5- to 4+ and his tibialis anterior was rated about a 5- on the left. His left patellar tendon reflex was depressed compared to the right side which was 1+. Assessment: Far lateral protrusion resulting in contact of the left L3 nerve. I believe he also has moderate stenosis at the foramen at the L4-5 segment. As such, I am going to recommend that we do a left-sided root block at L3-4, specifically I see at the left L3 root. I would also do the L4 root since I believe the protrusion is resulting in a combination of both root involvement resulting in the quadriceps weakness. I would do physical therapy and strengthening, but if he has progressive quadriceps weakness, then I would advocate for surgical decompression. On the other hand, if his pain is improved and his neurologic status is stable, we will observe him clinically and rehab him with physical therapy.

On February 27, 2012, X-rays, AP flexion/extension of the lumbar spine interpreted by revealed some relative collapse at the L4-5 area. No significant interval segmental instability on flexion or extension films.

On March 5, 2012, performed a UR on the claimant. Rationale for Denial: There was no mention of PT being done yet for this acute injury, so an injection would not be supported. The MRI showed left L2 and L3 root impingement but the request includes L4/5 which is not supported as there is no MRI evidence of HNP or nerve root impingement at this level. Therefore, the request is denied.

On March 14, 2012, performed a UR on the claimant. Rationale for Denial: I attempted a peer discussion with but was unable to reach him on multiple occasions.

Conservative care thus far appears to be Norco and activity limitations. It is unclear if the claimant has had prior injections or physical therapy, stretching, or oral anti-inflammatory medications. The claimant has a reported injury of a slip and fall out of a truck on 01/14/12. Given the above issues without the benefit of peer discussion, I cannot approve the proposed procedure as medically indicated at this time. There is no evidence the claimant has failed conservative care. There is no progressive neurologic deficit.

On March 19, 2012, the claimant had a follow-up evaluation with who reported that the claimant had 6 session of physical therapy following his injury in January 2012. The physical therapy reportedly aggravated his symptoms and did not improve it. Clinically, the claimant was exhibiting symptoms of a tibialis anterior weakness with diminished dorsiflexion of his left tibialis anterior. stated his imaging studies show a contact at the L2 nerve, however, he believed that his L4 nerve was involved clinically. On physical examination, the claimant had numbness and burning in the anterior left aspect of his thigh. His quadriceps was rated about 4/5 strength. His left tibialis anterior was rated 4/5. He has asymmetric reflexes on the left compared to the right in the patellar tendon reflex. He had quad atrophy. recommended a selective root block at the left L3 and L4 levels.

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

After reviewing the provided medical records, I would have to deny the request for selective nerve root injection left L3-4, L4-5. needs to be more specific in his request. According to the examinations, the claimant was recorded to have left quad weakness which would be L4 nerve root, anterior tibialis weakness which would be the L5 nerve root, and patella reflex changes which would be S1. We would need more specific plans for the diagnosis and treatment and what a left L3-4 selective nerve block would indicate. Specifically, how would a positive block change the course of treatment. Furthermore, the MRI performed on 02/10/12 showed left L2 and L3 root impingement but no impingement at L4/5. Although documented in his 03/19/12 report that the claimant did receive 6 sessions of physical therapy, there were no physical therapy records provided documenting failure of conservative care. Therefore, base on ODG guidelines, the request for selective nerve root injection left L3-4, L4-5 is not found to be medically necessary at this time.

ODG:

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

- (1) Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
- (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
- (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
- (4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two

injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.

(5) No more than two nerve root levels should be injected using transforaminal blocks.

(6) No more than one interlaminar level should be injected at one session.

(7) *Therapeutic phase:* If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

(9) Current research does not support a routine use of a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

Epidural steroid injections, diagnostic

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)**