

# CASEREVIEW

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## Notice of Independent Review Decision

[Date notice sent to all parties]: June 22, 2012

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L5-S1 Selective Nerve Root Block – RACZ Cath

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

This physician is a Board Certified Physical Medicine and Rehabilitation physician with over 16 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 medical necessity exists for each of the health care services in dispute.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

01/30/12: Evaluation by, MD with Pain Management  
02/15/12: MRI Lumbar Spine with and without contrast interpreted by, MD  
04/16/12: Authorization Request from Interventional Pain Management  
04/19/12: UR performed by DO  
05/02/12: Office Visit by, MD with Pain Management  
05/03/12: Appeal Authorization Request from Interventional Pain Management  
05/11/12: UR performed by MD

### PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx while at work. While putting something on a shelf she suffered a “ruptured disc at L6-S1”. It was recorded in the records that prior to 2003, the claimant underwent 3 separate disc surgeries: L3-4 laminectomy/discectomy in 1988, L5-S1 discectomy in 1999, and repeat discectomy L5-S1 in 2001.

On January 30, 2012, the claimant was evaluated by MD who noted she suffered from very low back pain and left posterior leg numbness. Her pain was described

as a constant ache on either side of the tailbone (R>L) with radiation of pain to the left infra-gluteal fold. She also described numbness in the back of her left thigh, back of her left heel, skipping the left calf. It was reported that she took Hydrocodone 7.5/750 mg approximately 4 times per week and had been on Naprosyn daily for many years as well as Flexeril. On physical examination she was able to lumbar flex to 90 degrees without pain and extend 10 degrees including side bend without pain. The claimant stated that lumbar rotation caused significant pain. SLR was negative in the seated and supine position as was Patrick's test and hip flexion, internal rotation. There was some tenderness to palpation of the peri-coccygeal muscles, but not of the coccyx itself. Diagnosis: Work comp related injury at L6 S1 by history, Previous spinal surgery at L3-4, L5-6, Neuropathic pain peri-coccygeal region and posterior left leg. Plan: MRI lumbar spine with/without contrast, Bilateral transforaminal L5-6 ESI from the caudal approach with RACZ catheter, Consider spinal cord stimulation, Narcotic agreement/urine drug screen, Stop Hydrocodone and begin Oxycodone 5 mg, and Liver function test and renal function test because of long usage of Naprosyn.

On February 15, 2012, MRI Lumbar Spine with and without contrast, Impression: Surgical changes at the L5-S1 level (There is severe disc desiccation in moderate to severe loss of disc height. There is vacuum disc phenomenon. There is an irregular circumferential disc osteophyte complex which in conjunction with disc height loss results in minimal left foraminal narrowing. There is no central spinal canal stenosis). No focal recurrent disc herniation at this level. There is multilevel degenerative disc disease and facet joint arthropathy involving significant spinal stenosis.

On April 19, 2012, DO performed a UR on the claimant. Rationale for Denial: MRI showed scar tissue but the physical exam is devoid any radicular findings. There is no clinical support for a SNRB based on this negative exam.

On May 2, 2012, the claimant was re-evaluated by MD who reported she had an increase in pain. Recommendation was made for a bilateral L5-S1 SNRB-RACZ-Cath.

On May 11, 2012, MD performed a UR on the claimant. Rationale for Denial: There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no current, detailed physical examination submitted for review, and the most recent physical examination dated 01/30/12 does not establish the presence of active lumbar radiculopathy noting negative straight leg raising and some tenderness. Attempts were made to reach the provider but were unsuccessful. \*\*Addendum: I discussed the case with Dr. at 1:10 pm CST on 05/10/12. Per telephonic consultation the epidural steroid injection will be via the caudal canal. The MRI shows scarring and defects. She has lost some reflexes. There is insufficient information to support a change in determination, and the previous non-certification is upheld.

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

Denial of Bilateral L5-S1 SNRB is upheld/agreed upon. Per ODG Low Back Chapter, submitted clinicals reveal no objective signs of radiculopathy and there is no notation of previous/more recent conservative care-particularly PT/Home Exercise Program. Therefore, the request for Bilateral L5-S1 Selective Nerve Root Block – RACZ Cath is not found to be medically necessary.

Per 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.)

**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)**