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Notice of Independent Review Decision

October 2, 2012

IRO CASE #:

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

OP selective nerve root sleeve injection #2 at L4-L5.

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

Physical Medicine and Rehabilitation Physician

**REVIEW OUTCOME:**

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

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:**

- Utilization review (08/20/12, 09/12/12)
- Office visits (09/28/11 - 09/04/12)
- Therapy (09/28/11 – 04/02/12)
- Diagnostics (10/10/11, 11/29/11, 08/06/12)

- Procedures (01/18/12, 07/16/12)
- Utilization review (08/20/12, 09/12/12)

**D.O.**

- Diagnostic (10/10/11, 08/06/12)
- Office visits (06/11/12 – 08/30/12)
- Procedure (07/16/12)
  
- Office visits (09/28/11 - 05/03/12)
- Therapy (09/28/11 - 04/09/12)
- Diagnostic (10/10/11, 11/29/11, 08/06/12)
- Reviews (01/11/12, 04/07/12, 05/22/12)
- Procedure (01/18/12, 03/14/12, 07/16/12)
- Utilization review (08/20/12, 09/12/12)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is male who on xx/xx/xx, was involved in a . The lasted for about 20 minutes. The patient was trying to and he was resistive and fought aggressively. As the patient had a hold of the person, they both fell to the ground. He twisted his left elbow and heard a pop with instant tingling sensations from the elbow into the fingertips as well as wrenching his neck and lower back during the altercation. Later his pain worsened.

On the next day following the injury, D.C., evaluated the patient for neck and low back pain. Examination showed significantly reduced and guarded cervical and lumbar range of motion (ROM), numbness and tingling radiating down the posterior lateral elbow into the palm and fingers and some hypersensitivity along the C5 through C8 dermatomes on the left. Cervical compression and distraction was positive bilaterally. Shoulder depression was positive on the left. Kemp's test was significantly positive. There was moderate spasm and tenderness through the cervical and lumbosacral gluteal and piriformis and the sacroiliac joints. There was tenderness about the left posterior lateral elbow, forearm and lateral epicondyle. Mill's test was mildly positive on the left. X-rays of the cervical, lumbar and elbow were unremarkable. Dr. assessed sprain of neck, sprain lumbar region, facet syndrome-other back symptoms, sacroiliitis, sprain radial collateral ligament, joint dis NOS-forearm. He treated the patient with muscle stimulation and ultrasound in combination with icing to the upper and lower back, cryo cuff to the left elbow, light myofascial release to the lower back and lower cervical musculature, to help relieve some of the spasm. The patient was placed off work.

From xx/xx, through April 2012, the patient underwent chiropractic therapy at Clinic and Rehabilitation Center under the care of Dr. , D.C. and, D.C.

In October, D.O., evaluated the patient for injuries to the low back. Examination showed lumbar paravertebral muscle spasm and tenderness, positive straight leg LHL602.

raise (SLR) bilaterally, back pain on hyperextension of the lumbar spine and tenderness of the lower lumbar facets. Dr. assessed low back pain with multiple potential etiologies, rule out discogenic component, rule out facet syndrome and rule out strain-sprain with myofascial dysfunction. He prescribed a non-steroidal anti-inflammatory medication, a muscle relaxant and a narcotic analgesic and recommended lumbar magnetic resonance imaging (MRI) and continuing therapy under Dr. supervision.

On October 10, 2011, MRI of the lumbar spine revealed: (1) Mild disc degeneration and facet hypertrophy at L4-L5 and L5-S1. (2) Central disc protrusion at L4-L5 and annular bulging at L5-S1 without significant spinal stenosis. (3) Mild bilateral neural foraminal stenosis at L5-S1 and minimal narrowing of the right L4-L5 neural foramen.

On follow-up, Dr. reviewed the MRI findings and opined that the patient's radicular symptoms were due to the neural foraminal stenosis occasioned by these acute disc injuries. The patient had failed to respond to conservative therapy. Dr. recommended stopping the anti-inflammatory medications and renewed pain medication and muscle relaxants. He recommended epidural steroid injections (ESI)

On follow-up, Dr. noted that the ESI was denied as there were no documented radicular symptoms although on initial evaluation. He recommended continuing therapy under Dr. supervision.

In a functional capacity evaluation (FCE), the patient demonstrated the ability to perform at light physical demand level (PDL).

Electromyography/nerve conduction velocity (EMG/NCV) study of the lower extremities showed S1 radiculopathy, bilateral sural neuropathy, chronic bilateral L4 radiculopathy and chronic left L5 radiculopathy.

In December, Dr. reviewed the EMG/NCV study. Examination showed positive SLR and radicular complaints. He opined that the patient met all diagnostic criteria for lumbar ESI and recommended lumbar ESI.

**2012:** On January 11, 2012, Dr. M.D., performed a designated doctor evaluation (DDE) and rendered the following opinions: (1) The back pain was secondary to an acute exacerbation and worsening of the underlying degenerative disc disease (DDD) at L5-S1. (2) The consequential inflammatory changes would also be a compensable injury i.e. radiculopathy at S1 nerve root. The DDD per se was a pre-existing injury and therefore, the pre-existing DDD should not be compensable. (3) The compensable injury was the acute exacerbation, worsening and acceleration of the pre-existing disease at L5-S1. (4) The sprain of the left elbow and left wrist had resolved.

In January, Dr. noted that the patient had undergone a DDE by Dr. who had opined that the patient was not at maximum medical improvement (MMI). Dr. recommended additional rehab after the injection.

On January 18, 2012, Dr. performed a lumbar ESI at L5-S1.

Dr. noted that the ESI had helped. He recommended continuing active PT.

In an FCE dated January 31, 2012, the patient demonstrated the ability to perform at light PDL versus heavy PDL required by his job.

In February, the patient was under the care of D.C., who treated him with therapeutic procedures, electrical stimulation, ultrasound and ice.

On March 14, 2012, Dr. performed lumbar ESI at L5-S1.

On follow-up, Dr. noted that the patient had a little bit of reduction of his complaints post injection. However, the patient had ongoing low back pain with numbness and tingling radiating down the right lower extremity to the foot and toes. The patient was maintained on home exercise program (HEP).

In April, Dr. noted that the second ESI had led to complete elimination of the patient's radicular pain. However, the patient had some back discomfort and difficulty with severe pain after his therapy sessions. He also had numbness and tingling most in the right foot but affecting the rest of his leg on an intermittent basis. Dr. assessed discogenic back pain with right leg neuropathic symptom. He renewed the pain medications and recommended a trial of gabapentin for neuropathic symptoms. He also recommended a surgical consultation.

In a subsequent FCE, the patient demonstrated the ability to perform at light PDL.

On April 27, 2012, M.D., performed a peer review and rendered the following opinions: (1) The patient at the most sustained lumbar and cervical strain/sprain injuries as a result of the injury. (2) He had a prior injury. (3) The findings on the MRI dated December 5, 2001, and October 10, 2011, were the same disc bulges with ongoing degenerative changes. There was nothing acute in the October 10, 2011, MRI to suggest that there was an acceleration/aggravation of his pre-existing degenerative changes. (4) Neural foraminal stenosis, disc degeneration and facet hypertrophy of lumbar spine, L4/L5 disc protrusion and annular bulge at L5/S1 were all pre-existing degenerative conditions and were not a diagnosis for the compensable injury. The patient's diagnostic testing did not show any evidence of acceleration or aggravation.

On follow-up in May, Dr. discontinued gabapentin as it made the patient sleepy and groggy. He recommended a trial of Lyrica and renewed the pain medications.

In May and June, Dr. noted that the patient had low back pain, tightness in the back and hip area and decreased ROM. He referred the patient to Dr. for orthopedic consultation.

On May 22, 2012, M.D., performed a DDE. He noted that the carrier had not accepted the lumbar disc pathology at L5-S1 as a compensable injury and the patient was scheduled for a Court Hearing to contest the extent of injury. Dr. opined that if the lumbar disc disease was not accepted then the patient would be at MMI but if the herniated disc was accepted then the patient was not at MMI and would be a candidate for surgery. Based on the accepted injuries the impairment would be 5% of whole person.

In June, D.O., evaluated the patient for complaints of lower back pain and right lower extremity numbness and pain. The patient had constant, burning, throbbing and cramping pain. He had numbness and tingling to the right lower extremity. Dr. assessed lumbago (intractable pain syndrome), lumbar spondylosis without myelopathy and lumbar radiculopathy at L4-L5 and recommended selective nerve sleeve injection at right L4-L5.

On June 14, 2012, PA, evaluated the patient for weakness and fatigue in his low back and back pain. Mr. assessed disc desiccation/degeneration and facet hypertrophy at L4-L5 and L5-S1. He recommended proceeding with the lumbar facet injection, possible rhizotomies at the L4-L5 and L5-S1 bilaterally. He also opined that the patient would not need a surgical intervention at that time.

On July 16, 2012, Dr. performed a lumbar selective nerve sleeve injection via the transforaminal approach at right L4-L5.

On July 22, 2012, the patient was evaluated at the emergency department for moderate and sharp back pain. M.D. assessed lumbar strain and prescribed Soma and Medrol.

On follow-up, Dr. noted that the patient had 40-50% pain relief in his back and had decreased numbness and tingling in the right foot after the injection. The patient had locking up of his back which went to the knee and worsening of his pain while getting dressed. He went to the emergency room (ER) and was treated with intramuscular injection of morphine. The patient reported that he felt like something was loose in back and his back pain had increased and was more intense. MRI of the lumbar spine was recommended.

On August 6, 2012, MRI of the lumbar spine showed the following findings: (1) 1.8 mm central disc protrusion at L4-L5 and minimal flattening of the thecal sac. (2) 1.8 mm central disc bulge or protrusion in the L5-S1 disc. (3) Dehydrated L4-L5 and L5-S1 discs.

On August 10, 2012, Dr. noted that the patient had low back pain. He had decrease in pain after selective nerve root block (SNRB) and there was

improvement in his activities of daily living (ADLs). He had decreased sensation in the right leg and sitting caused numbness in the right leg. Dr. recommended second selective nerve sleeve injection at right L4-L5.

Per utilization review dated August 20, 2012, the request for outpatient selective nerve sleeve injection #2 at right L4-L5 with C-arm was denied with the following rationale: *"It is the opinion of the reviewing physician that Claimant allegedly sustained a work injury in while. , lumbar MRI was interpreted as consistent with L4-L5 disc protrusion and L5-S1 annular bulge. Lower extremity electrodiagnostic studies were interpreted as consistent with bilateral L4 and left L5 chronic radiculopathy. No surgery is documented. Treatment to date has included physical therapy, chiropractic treatments and injections. Epidural steroid injections (ESIs) at L4-L5 and L5-S1 were authorized on January 5, 2012, and March 6, 2012. Right selective nerve root block (SNRB) at L4-L5 was authorized on June 20, 2012. Lumbar medial branch blocks (MBBs) were authorized July 13, 2012. Repeat lumbar MRI on August 6, 2012, was interpreted as consistent with L4-5 disc protrusion, as well as disc bulge or protrusion at L5-S1. July 23, 2012, provider note documented 40-50% reduction in back pain and less numbness/tingling in the right foot, 4 days s/p injection. Back pain was increased and was in a larger area. August 10, 2012, provider note documented complaints of low back pain which was decreased following SNRB, as well as decreased sensation to the right L5 dermatome. Official Disability Guidelines (Work Loss Data Institute. Web-based version) response criteria for repeat ESIs are not met. Non-authorization of this request is recommended."*

On August 22, 2012, Dr. noted that the patient had spinal pain. The last injection was denied. The patient had ROM deficit, pain and soreness. He reported that the first injection did help but the pain had returned. He had positive Kemp's test, tenderness and soreness. Dr. recommended a work-conditioning program.

On August 30, 2012, FNP-C, noted that the patient had 50% improvement after the block. His pain was controlled with medications. Ms. refilled the medications.

On September 4, 2012, a request for reconsideration (appeal) of the adverse determination for outpatient selective nerve sleeve injection #2 at right L4-L5 and C-arm was submitted. It was stated that the recommended treatment relieved the effects of the compensable injury and promoted recovery. The injection was reasonable due to the persistent pain dispute prior surgery and postoperative rehabilitation and was consistent with the ODG. The medical records established the clinical indication and necessity of the procedure.

Per reconsideration review dated September 12, 2012, the request for outpatient selective nerve root sleeve injection #2 on the right at L4-L5 with C-arm was denied with the following rationale: *"It is the opinion of the reviewing physician that this individual sustained a back injury on xx/xx/xx. On July 16, 2012, the claimant underwent lumbar facet medial branch nerve blocks bilaterally at L4-L5 and L5-S1. On July 16, 2012, an EMG demonstrated radiculopathy. At the July*

23, 2012, office visit (OV), there is a statement that the claimant's pain remained intense. At the August 10, 2012, OV, there is a mention that the pain was sixty (60) percent (%) improved. ODG require at least fifty (50) percent (%) pain relief for six to eight (6-8) weeks after the procedure. There is no documentation in this regard. The last OV was on August 10, 2012, which was three (3) weeks after the first (1st) selective nerve root block (SNRB). ODG are not met for the procedure."

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

The patient sustained an injury to his back, neck and arm on xx/xx/xx. The patient has undergone extensive conservative treatment consisting of Chiropractic treatment, exercises and medication management. Patient had an EMG that demonstrated a radiculopathy. MRI's have been consistent with symptoms showing disc/facet degeneration at L4/5 and L5/S1. The patient has had a total of three ESI's performed (Two(2) at L5/S1 performed by Dr. and one (1) at L4/5 performed by Dr.). Unfortunately, there is not sufficient documentation to clearly determine that the patient responded appropriately to the most recent ESI on 7/16/12. ODG requires at least fifty(50) percent pain relief for six to eight weeks after the procedure.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**