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Notice of Independent Review Decision

**November 8, 2013**

**IRO CASE #:**

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

Lumbar spine selective nerve root block at L5-S1, right side with sedation

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

Board Certified Pain Management 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 reviews (09/26/13, 10/15/13)
- Diagnostics (02/19/07 - 12/12/12)
- Office visits (08/08/07 - 09/18/13)
- Lumbar ESIs (08/08/07 – 07/15/08)
- Surgery (01/19/12)

**Review**

- Diagnostics (02/19/07 - 12/12/12)
- Lumbar ESIs (08/08/07 – 07/15/08)
- Office visits (08/08/07 - 09/18/13)
- Reviews (10/01/09, 03/08/10)

- Surgery (01/19/12)
- Utilization reviews (09/26/13)

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who on xx/xx/xx, was walking on a crosswalk when a truck did not stop and he injured his left knee, left elbow, left shoulder and lower back.

**2007:** On February 19, 2007, the patient underwent magnetic resonance imaging (MRI) of the lumbar spine for complaints of lumbar radiculopathy. Postoperative changes were suggested at the L4-L5 level where two well positioned cages were noted within the intervertebral disc space. Immediately above the operative site at L3-L4, a broad-based moderately compressive left paracentral disc herniation was observed.

On August 8, 2007, evaluated the patient for low back pain going down the right leg to the knee in an L5 and L4 distribution. It was noted that the patient had been referred. In 1999, the patient had a 360 degrees fusion at L4-L5 and did very well until he was hit by a vehicle as a pedestrian at work. He noted worsening back and left leg pain. reviewed the MRI findings, diagnosed low back pain, right lower extremity radiculopathy at L4 with some possible L5 involvement and referred the patient for epidural steroid injection (ESI).

From August 8, 2007, through January 11, 2008, the patient underwent lumbar ESI injections x4.

**2008:** On March 17, 2008, noted that the ESIs had helped the patient, but they had not given him significant long-lasting relief. The patient was utilizing tizanidine and Vicodin occasionally, but they were not working very well for the pain. prescribed Lyrica.

From March 26, 2008, through October 9, 2008, treated the patient with medication to include hydrocodone, Lortab, MS-Contin, Zanaflex (per recommendation), Ultram and Neurontin. performed a lumbar ESI on July 15, 2008.

On October 9, 2008, MRI of the lumbar spine showed: (1) At T12-L1, small midline disc protrusion with mild central canal stenosis. (2) At L1-L2, disc protrusion/extrusion to the right of midline with disc material extending 1.5 cm superior to disc space and posterior to L1 vertebral body causing mild-to-moderate central canal and right neural foraminal stenosis. (3) At L3-L4, small disc protrusion to the left of midline with annular tear causing mild central canal and left neural foraminal stenosis. (4) At L4-L5, interbody fusion cages anteriorly at L4-L5. Small residual endplate osteophytes causing slight central canal stenosis was noted.

X-rays of the lumbar spine revealed fusion of L4-L5 and mild diffuse spondylosis.

**2009:** On January 20, 2009, noted that the patient was reporting that Ultram was not helping him. He had not been able to take morphine and Neurontin. prescribed Lortab and recommended getting liver function tests.

On October 1, 2009, performed a designated doctor evaluation (DDE). The following additional information was gathered from the DDE report: *"X-rays of the cervical spine/chest/pelvis/left hip on xx/xx/xx, were unremarkable. X-rays of the lumbar spine dated xx/xx/xx, showed previous surgery at L4-L5. On January 15, 2007, evaluated the patient for low back and bilateral leg pain. He had been ambulated at the emergency room (ER) by ambulance. noted worsening of low back, right leg, left leg and left shoulder pain. He diagnosed internal derangement of left knee, lumbar radiculopathy and rotator cuff tendinitis of left shoulder and prescribed Vicodin and recommended MRI of the lumbar spine and left knee. The patient was maintained off work. Per electromyography/nerve conduction velocity (EMG/NCV) study dated August 21, 2007, there was electrodiagnostic evidence of possibly C6 and C8 radiculopathy with paraspinal reinnervation; however, based on the pattern of the muscles that were abnormal, it was opined that it was more likely from an anatomic standpoint that diagnosis #2 was noted. That was a lower trunk left brachial plexopathy. A lesion such as that would affect the abductor pollicis brevis and first dorsal interosseus as well as the axillary-innervated deltoid. Computerized tomography (CT) scan of the left elbow dated October 1, 2007, showed osteoarthritis. MRI of the brachia plexus dated October 1, 2007, was unremarkable. MRI of the cervical spine dated October 1, 2007, showed degenerative disc disease (DDD) with mild neural foraminal stenosis. Functional capacity evaluation (FCE) dated December 17, 2007, showed pain profile and functional deficit score of 9. The clients scoring 14 points of less could be considered to be objective pain clients. X-rays of the left elbow dated January 22, 2008, showed prominent anterior fat pad without acute fracture and mild degenerative change. On January 23, 2008, performed elbow arthrotomy, abrasion arthroplasty, capitellum, repair common extensor lateral epicondyle, left elbow. On April 23, 2008, had agreed with assessment and recommendation for a left knee arthroscopy. On June 4, 2008, had performed arthroscopy, partial lateral meniscectomy, abrasion arthroplasty, patellofemoral joint loose body excision and limited synovectomy of the left knee".* The patient's diagnosis was blunt trauma, left-side of the body-left shoulder, elbow and knee. The patient had reached maximum medical improvement on March 8, 2007, with 7% whole person impairment (WPI) rating. All the MRIs, x-rays, examinations and EMG were essentially normal and therefore, it was difficult to label any other diagnosis for the patient except blunt injury to the left side of the body to include the left shoulder, left elbow and left knee.

**2010:** On March 8, 2010, performed a peer review and rendered the following opinions: (1) The primary medical conditions referable to the work injury of xx/xx/xx, would include status post elbow arthrotomy, abrasion arthroplasty, capitellum repair of the common extensor lateral epicondyle, left shoulder, performed on January 23, 2008; status post left knee arthroscopy, partial lateral meniscectomy, abrasion arthroplasty, patellofemoral loose body excision and a limited synovectomy; contusions to multiple physical structure of the body. It

appeared that the definitive treatment was long ago provided to the left knee and left elbow. The records available for review did not provide any documentation to indicate the patient had been able to return to work activities. Based upon the records available for review, there would not appear to be a medical necessity for current medical treatment as it related directly to the work injury of xx/xx/xx. (2) There would not appear to be a medical necessity for prescription medication utilization as it related directly to the work injury of xx/xx/xx.

On March 9, 2010, prescribed hydrocodone and recommended MRI of the lumbar spine and electrodiagnostic studies of lower extremities. An ESI was also recommended.

On April 15, 2010, electrodiagnostic study performed showed evidence of mild subacute bilateral L5 and S1 radiculopathy. reviewed the MRI of the lumbar spine dated April 13, 2010, that showed previously disc protrusion at L1-L2 was no longer present. reviewed the MRI of the lumbar spine dated April 13, 2010, that showed previously disc protrusion at L1-L2 was no longer present. There was redemonstration of a left paracentral disc protrusion at L3-L4 which was broad-based with mild mass affect on the left lateral recess. An annular tear was suspected. There was an L4-L5 fusion cage. recommended an L3-L4 ESI with an L5 transforaminal injection on the right space since the patient was having pain in that distribution.

From May 24, 2010, through December 14, 2010, treated the patient with medications to include Ultram, Lortab and MS Contin. It was noted that the patient had also undergone a midline ESI at L3-L4 on April 30, 2010, which had helped the patient a great deal, but the ESI administered on July 17, 2010, did not give him as much relief as the previous one.

**2011:** On January 26, 2011, an orthopedic surgeon, evaluated the patient for significant debilitating back pain. diagnosed status post previous surgery with significant back pain that was limiting the patient's ability to function. He recommended more diagnostic information to the level of neural involvement with a computerized tomography (CT) myelogram.

On February 14, 2011, CT myelogram of the lumbar spine showed: (1) Interbody fusion hardware at L4-L5 with apparent mature osseous fusion. (2) There was mild diffuse loss of intervertebral disc height. (3) The conus medullaris terminated at the level of the mid body of the L1. (4) At T12-L1, a small broad-based disc bulge. (5) At L1-L2, a circumferential disc bulge. (6) At L2-L3, a tiny broad-based disc bulge. (7) At L3-L4, a large circumferential disc bulge with 3-mm left paracentral disc protrusion which mildly narrowed the left aspect of the spinal canal. Bilateral facet arthropathy was also present. There was narrowing of the left subarticular recess present with apparent contact and posterior displacement of the descending left L4 nerve root. (7) At L4-L5, a discectomy had been performed. Mild facet arthropathy was present. The spinal canal and neural foramina remained patent. (8) At L5-S1, circumferential disc bulge was present with bilateral facet arthropathy.

On March 9, 2011, reviewed the CT myelogram findings. He noted that the neurologic compression was seen more at the L3-L4 level. He recommended getting a formal evaluation since the patient had been out of work for four years. If it had been determined that he would be an appropriate candidate for further acute intervention, then would consider a discogram.

On March 28, 2011, performed a behavioral medicine evaluation. Based on the presurgical psychological screening the patient was cleared for discography without concern of psychological factors clouding results. If surgery was considered, the patient would be cleared for surgery with a fair to good prognosis for pain reduction and functional improvement.

On August 17, 2011, recommended a decompression at the L3-L4 level and stabilization of L3-L4.

**2012:** On January 19, 2012, performed full laminectomy with bilateral facetectomies at L2-L4 of transforaminal decompression, the posterior interbody fusion through the posterior approach at the L3-L4 segment, interbody fusion with placement of autograft as well as placement of cage from a posterior approach into the interbody space, pedicle screw instrumentation at L3 and L4, posterolateral fusion at L3-L4 and placement of epidural anesthetic with 3 mL of Duramorph, 2 mL of fentanyl and 5 mL of 0.5% Marcaine with epinephrine.

Postoperatively, from March 14, 2012, through December 12, 2012, treated the patient with tramadol. An x-ray dated December 12, 2012, showed a prior fusion at L3-L4 and L4-L5 levels. The alignment of the lumbar spine was anatomic.

**2013:** On March 13, 2013, noted that the patient had fusion at L3-L4 with excellent clinical improvement post-surgery. His pain and leg complaints were rated at about 4. He reported that he had some increasing pain radiating down on the right posterior buttock and thigh region consistent with an S1 radiculopathy. Because of that, he had undergone an MRI of the lumbar spine. prescribed tramadol. He recommended considering a right-sided selective nerve root block and ESI at the L5-S1 level if there would be significant worsening right-sided radicular complaints.

On September 18, 2013, evaluated the patient for pain in the posterior buttock and lateral thigh on the right hand side. suspected that the source of pain was coming from the inferior segment at L5-S1. The patient reported he was better than his preoperative status but he was having significant pain currently. Examination showed a tension sign on the right side. There was pain in the posterior buttock and the patient was having some numbness in the posterior margin on the right side. diagnosed previous fusion at L3-L4 and L4-L5 from industrial injury with evidence of right L5 and S1 nerve irritation and radiculopathy the intensity of which was about 5 to 6 at times with increasing pain up to about a 7 to 8 in the axial spine. recommended a right-sided selective root block with epidural injection on the right L5-S1 level.

Per the utilization review dated September 26, 2013, the request for lumbar spine selective nerve root block at L5-S1 on the right side with sedation was denied based on the following rationale: *“Based on the clinical information provided the request for a lumbar spine selective nerve root block L5-S1, right side with sedation is not recommended as medically necessary. The submitted physical examination fails to establish the presence of active lumbar radiculopathy and there are no postoperative imaging studies and/or electrodiagnostic result submitted for review. There is no comprehensive assessment of postoperative treatment completed to date or the patient’s response thereto submitted for review.”*

Per reconsideration review dated October 14, 2013; the request for reconsideration for lumbar spine selective nerve root block at L5-S1 on the right side with sedation was denied based on the following rationale: *“The request for a lumbar spine selective nerve root block at L5-S1 on the right with sedation is non-certified. The documentation submitted for review elaborates the patient complaining of low back pain with radiating pain into the lateral thigh and buttocks. The Official Disability Guidelines recommended diagnostic epidural steroid injection provided the patient meets specific criteria to include neuro-compressive findings confirmed by imaging studies as well as completion of conservative measures. There is no mention in the clinical notes regarding the patient’s recent completion of any conservative treatments. Additionally, no imaging studies were submitted confirming the patient’s neuro-compressive findings. Given this, the request does not meet guideline recommendations.”*

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

*Based on the records provided the request for a lumbar spine nerve root block L5-S1, right side with sedation is not recommended as medically necessary. The documents do not demonstrate a lumbar radiculopathy”*

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

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