



Claims Eval

Notice of Independent Review Decision

August 13, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Selective nerve root block at left L5 with intravenous sedation

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

American Board of Orthopaedic Surgery

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- 2-7-12 MRI of the lumbar spine without contrast.
- 2-10-12 Chiropractic Therapy Evaluation.

- 2-14-12, office visit
- 3-1-12, office visit
- 3-7-12, office visit
- 3-22-12, injection
- 4-3-12, office visit
- 4-3-12, office visit
- 4-17-12, office visit
- 5-1-12, injection
- 5-16-12, office visit
- 6-18-12, office visit
- 7-18-12 MRI of the lumbar spine with and without contrast
- 7-23-12 EMG-NCV
- 7-24-12 office visit
- 8-23-12, injection
- 9-25-12, office visit
- 11-26-12, office visit
- 12-12-12, office visit
- 3-28-13, office visit
- 4-18-13, office visit
- 5-16-13, injection
- 6-18-13, office visit
- 6-28-13, Medical Review

- 7-12-13, Medical Review
- 7-17-13, Medical Review

PATIENT CLINICAL HISTORY [SUMMARY]:

2-7-12 MRI of the lumbar spine without contrast, showed multilevel degenerative changes with large disc extrusion at L4-5 with associated neural compromise as described. Milder neural compromise secondary degenerative changes are noted at other levels. Right iliac crest lesion, likely reflecting a hemangioma, but somewhat atypical in appearance. Abdominal aortic aneurysm.

2-10-12 Chiropractic Therapy Evaluation.

2-14-12, the claimant complains of left low back and leg pain. Diagnosis: Acute left sciatica secondary to left-sided disk herniation at L4-5 with caudal migration. Plan: The evaluator reviewed with the claimant the signs and symptoms of cauda equina syndrome and the emergency that it would represent. At this point, he does have dorsiflexor weakness and he also needs to monitor this and obviously, if there is progression of his weakness, then this would be another indication for more urgent surgical consideration. The evaluator then discussed the results of the sport study comparing surgical versus nonsurgical intervention for herniated disk. At this point, he has to miss work. He is interested in at least discussing the case with the orthopedic spine surgeon in case it does come down to doing surgery sooner rather than later. The evaluator will make this request for him. In the meantime, the evaluator will start him with some physical therapy. The evaluator also added Lyrica to see if this will help with the neuropathic component of his pain. The evaluator will titrate his hydrocodone and the evaluator added Mobic as an anti-inflammatory. The evaluator would recommend electro diagnostic testing to objectively assess for axonal injury, particularly given his dorsiflexor weakness and his absent patellar reflex. The evaluator counseled him regarding smoking cessation and the impact this has on degenerative disk disease and as an independent risk factor for spine pain. The evaluator will see him back in the next couple of weeks for repeat evaluation, sooner if needed.

3-1-12, the claimant is seen in follow-up today. He is taking 2 hydrocodone per day which is down from 3-4 previously. He is taking Lyrica 4 a day and Mobic once. He has had his initial evaluation with physical therapy. He has a surgical consultation next week. He continues to have pain and really a tight band-like feeling over the medial dorsal foot and then some numbness laterally. His pain continues to go down from the buttock to the anterolateral shin. Electro diagnostic testing was performed today as previously planned. This reveals essentially normal left lower extremity nerve conduction study. He then has, on needle EMG testing, denervation

in the left anterior tibial is, peroneus longus, and gluteus medius. He has neuropathic recruitment in the gluteus medius. Two levels tested in the lower lumbar paraspinals are normal. Diagnosis: Left L5 radiculopathy with resolution-sparing of denervation in the paraspinals, L4-5 herniated disk with caudal migration. Plan: The evaluator reviewed with the claimant that he does appear to have a nerve injury to the L5 nerve root although today the evaluator does not see any active denervation in the paraspinals. Technically this would raise a suspicion for an extraspinal source such as a plexopathy. However, given his clinical picture, the evaluator thinks he may very well have other sparing of the medial branch or some resolution proximally and he now has some healing proximally and hopefully this will continue distally. He will continue to monitor his dorsiflexor weakness and obviously if this clinically worsens, the evaluator would have him consider surgery sooner rather than later. He will get in with the surgeon next week to at least get plugged in and discuss the specifics of surgery should he elect to proceed with that. In the meantime, the evaluator will request a left L5 selective block for further diagnostic/therapeutic purposes. He will also continue with his physical therapy treatments. At this point the evaluator will keep him off until he sees the surgeon next week but the evaluator think sif he continues to have some improvement he may release him to sedentary duty. He will continue with his current medications and the evaluator will see him back after the injection and after surgical consultation.

3-7-12, the claimant reported he injured himself on xx/xx/xx as he was lifting and pain started in this lower back. Since then he has back pain that radiates to left buttock down the lateral left hip and lateral calf causing pain into his feet. He reports he has constant pain. It is intense at times. He has been trying to work but is having issues with this. He has gone to 2 sessions of physical therapy. Also had EMG which showed L5 radiculopathy and is awaiting approval for a left L5 selective nerve root block. He takes meloxicam, Lyrica, Vicodin Lipitor, lisinopril, and verapamil and wants to see what the evaluator can do from a surgical standpoint. He rates his low or back and leg pain 2/10 today. He has had previous MRIs of the lumbar spine which show a large disk herniation tracking caudally on the left L4-5 and this MRI was obtained on 2-7-12. Impression: Large lumbar disk herniation L4-5 left with resultant radiculopathy, pain and weakness. Plan: At this point, the claimant is going to undergo a maximum nonsurgical care with injections, activity modification, and oral medication. The evaluator has advised him that if his pain and weakness do not show notable improvement here in the next week or two recommendation would be made to him to excise this large disk fragment. He is to follow up. The evaluator will be happy to see him if further surgical discussions are of interest.

3-22-12, preoperative and postoperative diagnosis: Lumbar radiculopathy. Procedure: Selective Nerve Root Block L5, Left. Contrast Study of nerve root sleeve and-or epidural space (Epidurography). Fluoroscopic Guidance IV Conscious Sedation.

4-3-12, the claimant comes in today with his wife complaining he is still having significant weakness to that left leg, atrophy of the left calf, and difficulty with dorsiflexion and EHL and has seen recently, has not had good relief from the injection. The weakness still persists. Physical therapy is not helping, so he wants to see if he can proceed with surgery as previously discussed. He is still taking hydrocodone, Lyrica, and meloxicam, and is trying to consider going back to work and is doing desk duty until he can get surgery approved since the weakness is debilitating him. Diagnosis: Left L5 radiculopathy, L4-5 herniated disk with caudal migration. Plan: The evaluator discussed with the claimant that as previously with, the evaluator will proceed with laminectomy-diskectomy at that 4-5. The evaluator will plan to see him back 2 weeks post or certainly sooner if needed. The evaluator will proceed with the scheduling of surgery. The risks, benefits, and surgery itself were all discussed with him. He verbalized understanding and they will proceed with surgery.

4-3-12, the claimant is seen in follow-up today with his wife. He states that his proximal pain has improved with the selective block, but he does continue to have distal weakness and numbness that is unchanged. He is taking Lyrica 2 a day and half a Vicodin one or two times a day and that seems to help control his pain. He remains off work. At this point, he feels like he could do most of his job duties and really avoid some of the lifting and other things that he would not be able to tolerate but as far as the walking and standing, he thinks he could do it. Diagnosis: Subacute left sciatica secondary to L5-S1 disk extrusion. Plan: The evaluator reviewed with the claimant expectations of nerve healing and really the fact that even if he has a diskectomy, his numbness and weakness will not necessarily resolve overnight but the surgery may help expedite recovery and at this point, he is just really interested in doing the surgery as opposed to "monkeying" around with further injections. The evaluator thinks this is reasonable. The evaluator will have him get back in as he discussed a few weeks ago proceeding with diskectomy if he did not have significant improvement by the end of the month in 3-12. He would like to do a trial of full duty as obviously it is not clear how quickly he will be able to have surgery. In the meantime, he will continue with his home exercises and medications and the evaluator will see him back following his recovery from surgery.

4-17-12, the claimant is here for preop teaching for an upcoming laminectomy-diskectomy for persistent and profound weakness in the lower extremity. This claimant has observable atrophy and on exam today, weakness graded 3-5 on his left EHL and 4-5 in the anterior tib. He has dysesthesias in an L5 distribution predominantly but no severe pain. He understands the indications, risks, benefits, and expected outcome of this surgical procedure versus continued nonoperative care. He wishes to proceed with surgical decompression in hopes of improving the chances for regaining his strength. He is scheduled for surgery here in the next few weeks, expected two-night hospital stay.

5-1-12, preoperative and postoperative diagnosis: Lumbar disk herniation, L4-5 left, lumbar radicular syndrome. Procedure: Microdiscectomies L4-5 left. Operative use of microscope. Placement of AmnioClear tissue graft. Intra-operative neuromonitoring dictated separately.

5-16-12, the claimant comes in today reporting he is here to follow up after surgery. He is overall doing worse. He feels that the pain in his leg is more intense and he just wanted to be better by now. He wants to see what the next step is. Diagnosis: Stable postoperative course following laminectomy-discectomy at the left L4-5 on 5-2-12. Plan: The evaluator discussed with the claimant at this point they need to get him into physical therapy. The evaluator will also try a short round of steroids. The evaluator will refill his meloxicam. He will start once he has finished the steroid and increase his Lyrica. The evaluator will give him more time and if he fails to improve, then consider EMG or repeat MRI. The evaluator will plan to see him back in 4 weeks for repeat evaluation or sooner if needed.

6-18-12, the claimant still has this left buttock pain that radiates down the left lateral leg and posterior calf as well as the top of the foot. He reports it is getting more intense. It is still affecting his walk and he is unable to stand or walk for very long. Even if he stands for 10 minutes, it is very difficult. He has to sit down. Sitting and lying down, he has no problem. He is currently doing physical therapy and feels that it has increased somewhat but still is having weakness and difficulty so he wants to see what the next step is. He still takes Hydrocodone three a day, meloxicam one a day, and Lyrica three a day. Diagnosis: Continued lumbar radiculopathy status post laminectomy-discectomy at the left L4-5 on 5-2-12. Plan: The evaluator discussed with the claimant at this point they do need to get MRI with contrast for further investigation of his symptoms. The evaluator also has submitted for an EMG to assess his neurological status in the lower extremities. The evaluator will plan to see him back after both tests to discuss the results.

7-18-12 MRI of the lumbar spine with and without contrast, showed postsurgical changes of left sided laminectomy at the L4-5 level. Hypointense focus extending into the left lateral recess, surrounded by enhancement, contiguous with the adjacent L4-5 disk and suspicious for small focal disk protrusion with surrounding granulation tissue present. This produces mild mass effect on the medial aspect of the left L5 nerve root and the left anterior thecal sac. Mild posterior diffuse disk bulging at L5-S1 producing slight effacement of the anterior thecal sac but no significant nerve root impingement. Incidental note is made of a small infrarenal abdominal aortic aneurysm extending from the L3 through L4 level. Otherwise negative MRI lumbar spine with and without contrast.

7-23-12 EMG-NCV, showed abnormal study. There is electrodiagnostic evidence of an improving L5 radiculopathy as compared to findings in March of this year that

preceded his discectomy. There is evidence of collateral sprouting. These findings and the recommendations below were discussed with the claimant.

7-24-12, the claimant returned for follow-up. There are surgical scars at the lumbar spine that are well healed. He stands erect. His gait is balanced. His pelvis is level with the floor. Assessment: Chronic low back pain with left leg radiculopathy secondary to left-sided L4-5 recurrent disc herniation with caudal migration and scar tissue. Noted improvement in EMGs. Plan: Left SNRB L5 for diagnostic/therapeutic purposes. Increase Lyrica. RTC 2 weeks after injection.

8-23-12, preoperative and postoperative diagnosis: Lumbar radiculopathy. Procedure: Transforaminal epidural steroid injection (selective nerve root block) L5-S1 left. Fluoroscopic guidance.

9-25-12, the claimant had a SNR L5 on 8-17-12. He is doing much better after this. He reports that his leg pain is just about completely gone. Overall, he feels 95%+ better. He reports he has appointment next week for urination difficulties and sexual problems as well as appointment with GI specialist for his colonoscopy and well check. Assessment: Chronic low back pain with left leg radiculopathy secondary to left-sided L4-5 recurrent disc herniation with caudal migration and scar tissue improved with Left SNRB L5. Previous improvement in EMGs. Plan: RTC prn. Repeat SNRB prn. Follow-up for continue treating doctor follow ups and medication refills. was present and agrees with above.

11-26-12, the claimant continues to complain of some left leg weakness and dysesthesia. It is worse in the mornings. He takes hydrocodone and Lyrica 3 times a day each. He had a 15 selective block done in August and this lasted a couple of months. He continues to complain of bladder problems and low sex drive. He has seen an urologist who put him on androderm gel but at this point he has not noticed any change. He is also on verapamil, lipitor and lisinopril. Assessment: Chronic low back pain with left leg radiculopathy secondary to left-sided L4-5 recurrent disc herniation with caudal migration and scar tissue improved with Left SNRB L5, denervation improvement noted on serial EMGs. Plan: The claimant was warned against the signs and symptoms of cauda equina syndrome and progressive radiculopathy and the emergency these would represent. At this point, there is no surgical emergency. The evaluator will do a trial of tramadol and place of his hydrocodone to see if he gets adequate analgesia and to see if his libido improves. If not, the evaluator will change him back to hydrocodone. The evaluator will otherwise see him back in a few months. The claimant will follow-up with the primary care physician (and other providers) for ongoing health maintenance needs. He has been placed at maximum medical improvement and reported 10% whole person impairment by a designated doctor.

12-12-12, the claimant is here today for continued low back pain. He reports he fell this morning and the pain began at that time. He went to a coughing spells and

almost fell to the ground but caught himself with his arms and has seconds of increased pain but this afternoon it is slightly better. He was concerned that he messed something up and wants to be seen. Assessment: Chronic low back pain with left leg radiculopathy secondary to left-sided L4-5 recurrent disc herniation with caudal migration and scar tissue improved with Left SNIP L5, denervation improvement noted on serial EMGs, acute flare of lumbar radiculopathy. Plan: RTC 1 week if fails to improve or sooner if needed. He will continue home exercises. Start ice/heat pm pain. The claimant was prescribed Naprelan 500mg.

3-28-13, the claimant is being seen today for lower back and left leg pain. The claimant also needs medication refills. His wife accompanies him today and his pain has increased and is affecting his life and wants to do something about it. Assessment: Chronic low back pain with left leg radiculopathy secondary to left-sided L4-5 recurrent disc herniation with caudal migration and scar tissue improved with Left SNIP L5, denervation improvement noted on serial EMGs, acute flare of lumbar radiculopathy. Plan: The evaluator will repeat Left SNRB L5. RTC to discuss surgery options. Continue lyrica and norco for pain.

Follow-up visit on 4-18-13 notes the claimant is to follow through with ESI already ordered. If pain persists after ESI, consider reimaging with CT myelogram and repeating EMG. If no surgical lesion noted, consider SCS for treatment of chronic pain/radiculopathy. Long term, if medical pain management continues to be at issue, consider Spinal Rehab etc.

5-16-13, preoperative and postoperative diagnosis: Lumbar radiculopathy. Procedure: Transforaminal epidural steroid injection L5-S1 left. Fluoroscopic guidance.

6-18-13, the claimant is being seen today to follow-up from an injection. The claimant felt great for about 2 week after the injection then the pain started coming back. Assessment: Chronic low back pain with left leg radiculopathy secondary to left-sided L4-5 recurrent disc herniation with caudal migration and scar tissue improved with Left SNRB L5, denervation improvement noted on serial EMGs, persistent pre operative pain and weakness after surgical decompression and interval time hoping for recovery due to improving EMG. Plan: Since pain was so dramatically improved initially, the evaluator has recommended a repeat injection to try and maximize his recovery. Have discussed medication usage with claimant at today's visit. The claimant was prescribed Butrans.

6-28-13, performed a Medical Review. It was his opinion based on the information provided, another L5 Selective Nerve Root Block is not medically necessary for this claimant. The claimant has had surgery for discectomy. There were signs of radiculopathy on exam. He had only two weeks of pain relief with the last epidural steroid injection. There was improvement on his electromyogram study and MRI in appearance of the radiculopathy. There was no documentation of at least 50-70%

relief for six to eight weeks. As a result, the request for a repeat epidural steroid injection cannot be established as medically necessary at this time per evidence based guidelines. Therefore, another L5 selective nerve root block is not medically necessary for this claimant.

7-12-13, performed a Medical Review. It was his opinion that the appeal for selective nerve root block at left L5 with intravenous sedation is not medically necessary. The recommendation for the requested Selective Nerve Root Block at the left L5 is non-certification as the claimant did not have an adequate response as recommended by ODG with 50 percent benefit for six to eight weeks prior to considering a repeat injection. Therefore, appeal for selective nerve root block at left L5 with intravenous sedation is not medically necessary.

7-17-13, performed a Medical Review. It was his opinion that the recommendation for the requested selective nerve root block at the left L5 is non-certification as the claimant did not have an adequate response as recommended by ODG with 50 percent benefit for six to eight weeks prior to considering a repeat injection. Therefore, appeal for selective nerve root block at left L5 with intravenous sedation is not medically necessary.

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

Medical records reflect a claimant with a history of disc extrusion at L4-L5. The claimant was treated with medications and physical therapy. He underwent nerve root blocks on 3-22-12. Eventually, he underwent L4-L5 microdiscectomy. Postop, he continued with radicular complaints and was given a transforaminal epidural steroid injection on 8-23-12 with reported 95% pain relief. The pain eventually returned and on 5-16-13 and the claimant underwent a second transforaminal epidural steroid injection on 5-16-13 with reported only two weeks pain relief.

Based on the records provided, and current guidelines, a repeat injection would not be indicated, as the claimant did not obtain at least 50-70% pain relief for at least 6-8 weeks. He had short term and limited pain improvement. Therefore, the request for selective nerve root block at left L5 with intravenous sedation is not reasonable or medically necessary.

Per ODG 2013: 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)**