

Health Decisions, Inc.

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Notice of Independent Review Decision

July 14, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Selective Nerve Root Block L2-L3, L4-L5

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

Board Certified Orthopedic Surgeon with over 42 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:

01-24-14: Office Visit Report with Appended Note
01-24-14: Physical Therapy Visit Report
01-30-14: Physical Therapy Visit Report
01-30-14: Progress Note
02-06-14: MRI interpreted
02-06-14: Physical Therapy Visit Report
02-07-14: Physician Work Activity Status Report
02-07-14: Progress Note
02-13-14: Physical Therapy Visit Report
02-21-14: Office Visit Report
03-07-14: Office Visit Report
05-23-14: URA
05-29-14: Office Visit Report

06-16-14: URA

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male that was injured at work when he slipped on some ice falling and landing on his low back and buttocks. This occurred on xx/xx/xx. The claimant was diagnosed with lumbar sprain. The conservative treatments he has utilized are steroids, muscle relaxers and PT without adequate relief.

Xx/xx/xx: Office Visit Report with Appended Note. The claimant presents with constant, burning low back and buttocks pain that is radiating down both legs. He states right side worse than left and rates pain 4/10. Upon examination, the claimant has tenderness on lumbar area at level L4 – S1 and bilateral SI joints. He has positive straight leg raise bilaterally at 60 degrees. The claimant refuses to do ROM testing. X-Ray Report on Lumbar Spine 3 Views: Osteophyte noted arising from the upper left corner of the L3 vertebral body on the AP view; the osteophyte curves in a downward direction. Old/chronic avulsion/chip-type fracture noted at the anterior and superior corner of the L4 vertebral body on the lateral views. No acute processes are noted. Assessment: 1. Back/buttock contusion. 2. Lumbar strain. 3. Fall on the same level from slipping/tripping. Plan: Recommend PT (6 sessions), Flexeril and MRI of lumbar spine. Appended Note: Spoke with center director regarding MRI and changing it to a CT or other imaging study, as patient has metallic surgical clips/staples that were found on lumbar spine x-rays. The claimant at visit was sent back to work without restrictions, this was modified to no bending forward at the waist.

Xx/xx/xx: Physical Therapy Visit Report. Therapy Initial Evaluation: The claimant c/o R low back, buttock pain. Pain radiates to R anterior and lateral thigh. Posture: Weight shift to L in stance, sitting. Transitional Movements/Function: Guarded gait; no deviations noted. Hip MMT: Left, Right, flexion 5/5, 5/5, extension/abduction NT. Lumbar AROM: Flexion 90% limited, extension WNL, lateral flexion L WNL, R WNL, rotation L WNL, R 60% limited. Myotomes: L2 hip flexion L 5/5, R 5/5; L3 quadriceps L 5/5, R 5/5; L4 tibialis anterior L 5/5, R 5/5; L5 extensor hallucis longus L 5/5, R 5/5; S1 gastroc/soleus L 5/5, R 5/5. Passive Intervertebral Accessory Motion: Hypomobile R SI, hypomobile L4, 5 on R, L sacral torsion. Facet Joint Pathology: Extension rotation test Pos on R. The claimant reported decreased pain following lumbar gapping manipulation. Assessment: Subjective report is consistent with objective findings.

01-30-14: Physical Therapy Visit Report. Rotation: L WNL, R 50% limited. Special Tests: SLR test supine Pos on R.

01-30-14: Progress Note. The claimant states he is doing better with low back pain 4/10 with intermittent radiation to R anterior thigh. He states PT is helping. Upon examination, neurologically has negative SLR, musculoskeletal: SLR is negative bilaterally, lumbar ROM is decreased to flexion extension mildly with

pain, and palpation is positive for pain at L3 L4 L5 bilaterally. Assessment: 1. Lumbar radiculopathy. 2. Lumbar strain. Plan: Increase Flexeril.

02-06-14: MRI interpreted. Findings: The conus medullaris extends to L1. No pre or paravertebral soft tissue masses are seen. There is focal compaction within the anterior aspect of the superior endplate of L4. A small bone fragment is present adjacent to the compacted L4 vertebral body endplate. This may be a small avulsion fraction from the anterior aspect of the superior endplate of L4. There is mixed bone edema and Modic Type II endplate change within the portion of the endplate. Both an acute and a long-standing component are present. There are small benign vertebral body hemangiomas within L2 and L4.

02-06-14: Physical Therapy Visit Report. The claimant c/o some pain when walking for long periods of time. He states the pain is 4/10. Upon examination, Posture: weight shift to L in stance, sitting. Tenderness to palpation at R PSIS, SI jt.

02-07-14: Progress Note. The claimant c/o constant, burning pain down the right leg. He reports that has had PT 3 times and is not helping. Sitting and leaning forward with pressure on the hands causes the pain to increase. Upon examination, Lumbar: Positive SLR on the right at 30 degrees. Pain with flexion to 90 degrees. Sidebending left to 30 degrees with pain. Pain with extension to 10 degrees. Hip flexion right increase pain. Sensation intact. Assessment: 1. Herniated Disc pulposus with Radiculopathy. 2. Back pain. 3. Back strain. Plan: 1. Refer to Ortho spine.

02-21-14: Office Visit Report. The claimant c/o pain in low back midline bilaterally and down his right anterior thigh that is worse with use. He states that after PT his right thigh pain is worse. Upon examination, his gait is slow and purposeful. He does have difficulty acquiring a full, upright position when getting out of a chair. Plan: Recommend and refer for PT specific to the back and Medrol dose pack.

03-07-14: Office Visit Report. The claimant states he has some relief after the second Medrol dose pack, but the benefits were short lived. He has not returned to PT and has some tingling in the left anterior thigh. Assessment: Cervical muscle strain, lumbar intervertebral disc without myopathy – LRS. Plan: Recommend return to PT and selective nerve root blocks L2-L3, L4-L5.

05-23-14: URA. Rationale: The clinical information submitted. The medications were not provided. The surgical history was not provided. The diagnostic studies included an MRI of the lumbar spine without contrast on 02/06/2014 with an official read which revealed at L2-3, a 1 mm retrolisthesis and a broad 2 mm disc protrusion/herniation with a 3 mm left posterolateral component causing mild thecal sac stenosis and mild bilateral neural foraminal narrowing, left greater than right; and at L3-4, there was a 1.5 mm retrolisthesis and a broad 2 mm disc protrusion/herniation with thecal sac stenosis and mild bilateral neural foraminal

narrowing. Other therapies included physical therapy. The documentation of 03/07/2014 revealed that the patient had complaints of sharp, stabbing and burning pain in the low back across the midline and bilaterally down his right anterior thigh, worse with use. The patient indicated that he has some relief after a second Medrol Dosepak. The Official Disability Guidelines recommend diagnostic epidural steroid injections to determine the level of radicular pain in cases where diagnostic imaging is ambiguous and to help evaluate a radicular pain generator when physical signs and symptoms differ from those found on imaging studies. The clinical documentation submitted for review failed to provide an objective physical examination to support the necessity for a diagnostic epidural steroid injection. There was a lack of documentation indicating that the patient had nerve impingement upon MRI. The epidural steroid injection would not be supported. Official Disability Guidelines indicates that there is no evidence-based literature to make a firm recommendation as to sedation during an epidural steroid injection. There was a lack of documented rationale for the use of sedation. The request for IV sedation would not be supported. Given the above, the request for a selective nerve root block at L2-3 and L4-5 is non-certified.

05-29-14: Office Visit Report. The claimant c/o worsening left low back, buttock and right anterior lateral thigh. He continues to c/o weakness in the lower extremities that is worse on right side. Upon examination, spinous processes have point tenderness around T9 area right facet area. Paravertebral muscles are tender on the right. Lumbar ROM WNL. Assessment: Pain in thoracic spine, lumbosacral neuritis or radiculitis and LBP. Plan: T Spine AP/LAT, myelogram of lumbar spine w/CT w/IV protocol, Flexeril and Medrol Dosepak.

06-16-14: URA. Rationale: An appeal was made for Selective Nerve Root Block at L2-L3 and L4-L5. The prior non-certification was issued since the provided MRI was not ambiguous or inconclusive; the physical examination did not document any significant signs of radiculopathy; and there was no documentation of sensory changes, motor weakness and/or deep tendon reflex changes that are in a pattern that was inconsistent with the findings on the MRI. Clarification is needed regarding the spinal levels and laterality to be injected. The Guidelines indicate that there was no evidence-based literature to make a firm recommendation as to sedation during an epidural steroid injection. Moreover, MRI findings were not submitted for review. Finally, the documents submitted for this appeal did not contain objective findings in the lumbar spine and lower extremities with neurologic deficits supporting presence of radiculopathy. In agreement with the previous determination, medical necessity of the requested procedure cannot be determined at this juncture.

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

The previous adverse determinations are upheld. The MRI does not show an operable lesion. There were no documented objective clinical findings of radiculopathy, such as reflex changes, motor weakness or sensory changes in the

records provided. There is no indication that a selective nerve block would aid in the diagnosis or treatment. Therefore, the request for Selective Nerve Root Block L2-L3, L4-L5 does not meet ODG guidelines and is not found to be medically necessary at this time.

Per ODG:

Epidural steroid injections, diagnostic	<p>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:</p> <ol style="list-style-type: none">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.
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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 (due to herniated nucleus pulposus, but not spinal stenosis) 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)**