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Notice of Independent Review Decision

July 31, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left L4-L5, L5-S1 Selective Nerve Root Block

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This reviewer is a 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old who was injured when he fell at work.

07/23/2010: History and Physical. **HPI:** The patient is a xx year old who is non-ambulatory at this time. He had to crawl when he came into my clinic. His pain is severe. He was essentially bed bound. This all started with a Worker's Comp injury that started when he fell while he was at work. He has been to the emergency room several times. His pain is only poorly controlled with oral medications that have been prescribed. He has to use a wheelchair or crawl to get around the office. The plan is severe intractable low back pain radiating down the left lower extremity. **Physical Exam:** I examined the patient while he was lying supine in the hospital bed. In the upper extremities, strength is graded 5/5 in the deltoids, biceps, triceps and wrist extensors and finger flexors. No hyper flexion. Hoffman's sign is absent. In the lower extremities on the right side, 5/5 gastric soleus, anterior talus, extensor halluces longus, quadriceps and hamstrings. On the left-side, weakness is graded 4/5 in the gastric solena, anterior taius, extensor halluces longus. Tension signs are positive on the left reproducing back pain and left leg pain severely. **Impression:** L5-S1 disc herniation. **Plan:** We had a discussion with the patient and the family regarding possible treatment options. Non-operative treatment could include more pain medications or steroid injections, but given the fact that the patient has significant weakness, he is incapacitated, he is non-ambulatory, he elected to proceed with lumbar discectomy. The risks are inclusive of but not exclusive of bleeding, infection, nerve damage, chronic pain, need for reoperation. There is also risk of disc herniation, disk

degeneration and possible need for further surgical intervention which could occur at L5-S1 or at another spinal level. Cognizant of the risk of surgery, the patient's informed consent was obtained. The patient will proceed with lumbar discectomy.

07/23/2010: Operative Report. **Post-Operative Diagnosis:** 1. L5-S1 herniated disc. 2. Lumbar radicular pain. **Procedure:** 1. Left L5-S1 discectomy. 2. Nerve monitoring.

07/23/2010: X-Ray of the Lumbar spine. **Findings:** Numbering system of vertebral bodies is based upon the inferior mo: normal disc level representing L5-S1 level. Metallic density projects over the L5-S1 disc space. Additional metallic density projects to the posterior aspect of the L5 vertebral body. **Impression:** 1. Intraoperative localization as above

11/05/2010: Follow-up Visit. **Subjective:** Patien is now three months out from his lumbar discectomy. He has been getting improvement of his left leg pain, but he has some minor low back pain. He takes Advil over-the-counter. He is working full time now. **Objective:** Strength is graded 5/5 in the bilateral gastrosolens, anterior tibialis, extensor halluces longues, quadriceps, and hamstrings. Tension signs on the asiatic nerve are negative. **Plan:** Working full time with no restrictions. He can continue. Home exercise. Doing well. Follow up in 6 months.

11/23/2010: MRI Lumbar Spine Without Contrast. **Impression:** 1. Multilevel disc degenerative disease. 2. Small disk protrusion superimposed upon a broad based disk bulge at the L5-S1 level. This significantly narrows the left lateral recess with possible impingement of the descending S1 nerve root on the left. 3. Small central extrusion at L4 L5 with minimal candal migration. 4. Postsurgical changes at the L5-S1 level.

11/23/2010: On Call Note. I got a call from patient saying that he is a patient and he had what he described as a discectomy back on July 23, 2010. He states that yesterday, he was bending over and he felt a sharp pop in his back and has been having severe pain ever since. He states he will likely wait until 9 a.m. and call the office at that time.

09/29/2011: Physical Therapy Status Report. Reported increased pain in low back and left upper buttock last visit. Reported, "It seems to hurt more every day." Lumbar ROM 09/14/11 Flexion: 34°-increased center low back, Extension: 12°-increased center lb, Rt side bend: 15°-increased center lb, Left side bend: 12°-increased center lb., Rt rotation: WNL-increased right rotation, Left rotation: WNL-increased left rotation. Right SLR: 68°, Left SLR: 68°-increased low back. Patient is not progressing as expected. Recommend doctor re-eval.

09/29/2011: Radiology Report. **Impression:** Three view of the lumbar spine was taken today. There is no scoliosis noted. No spondylolisthesis. There is loss of disc height at the S-1 and 4-5 levels. No instability noted.

05/03/2013: MRI Lumbar Spine. **Impression:** 1. Status post left-sided laminotomy at L5-S1. There is a hypertrophic appearance of the facet joints. Some enhancing soft tissue is identified adjacent to the left __ nerve root aleava most compatible with granulation tissue. Some enhancement is noted along the posterior central aspect of the annulus likely representing some post discectomy charges however a disk protrusion with small annular fissure would be difficult to completely exclude. Overall the appearance are similar to the prior study. 2. 5-6 mm broad-based posterior disk protrusion at L4-5 now containing an annular fissure with degenerative facet joint changes causing mild central canal narrowing. The caliber of the central canal is similar to the prior study. 3. 2 mm annular bulge at L3-4 with asymmetric extension into the left neural foramen and far left lateral region effacing some of the fat _____ the left L3 nerve root. This is similar in appearance to the prior study.

05/23/2014: Office Visit. **HPI:** Patient underwent a lumbar ESI with good relief for a few months, but now the pain has recurred, left leg pain with weakness, continues to work as a surveyor. **Assessment:** 5/5 strength on the right side. 4/5 left and to tibialis and EHL. Tension signs positive bilateral worse on the left than the right. No assistive aids no hyperreflexia and no clonus. Mildly antalgic gait favoring the left leg. **Plan:** Post laminectomy syndrome, lumbar radicular syndrome. Left L4-5 L5-S1 transforaminal ESI. Oral medications as needed. Hydrocodone and Zanaflex

06/02/2015: Office Visit. **HPI:** Patient underwent an injection last year and had good relief for approximately 11 months. Pain has now recurred over the last one month. He would like another injection. **Assessment:** 5/5 strength in bilateral upper and lower extremities. Tension signs mildly positive on the left side only. No assistive aids no hyperreflexia and no clonus. Mildly antalgic gait favoring the left leg. **Plan:** Left L4-5, L5-S1 transforaminal ESI. He had a good response last time, and we'll see how he does this time. Oral medications as needed. Hydrocodone 10 mg Norco 3 per day, physical therapy, add topical, follow-up after injection. If no improvement, consider new MRI lumbar spine with contrast and surgical workup.

06/08/2015: UR. **Rationale for Denial:** The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The patient is a xx year old who was injured on xx/xx/xx when he fell backwards on a bunch of boulders. He is diagnosed with lumbar post laminectomy syndrome and lumbar radicular syndrome. A request is made for left L4-5 and L5-S1 selective nerve root blocks. The patient has been experiencing low back and left leg pain. He had undergone left L5-S1 discectomy on 07/23/2010. Other documented treatments included bracing, medications, and physical therapy. Lumbar MRI dated 5/3/13 demonstrated status post left sided laminotomy at L5-S1, hypertrophic appearance of the facet joints, some enhancing soft tissue adjacent to the left S1 nerve root sleeve most compatible with granulation tissue, and some enhancement along the posterior central aspect of the annulus likely representing post discectomy changes but a disc protrusion with small annular fissure was difficult to exclude. At L4-5, there was a 5-6 mm broad-based posterior disc protrusion now containing an annular fissure with degenerative facet joint changes causing mild central canal narrowing. At L3-4, there was a 2 mm annular bulge with asymmetric extension into the left neural foramen and far left lateral region effacing some of the fat anterior to the left L3 nerve root. As per 6/2/15 follow-up, the patient presented with low back and left leg pain. He had an injection last year which provided good relief for approximately 11 months. The pain had returned over the past month and he would like another injection. Examination revealed mildly positive tension signs on the left side, mildly antalgic gait favoring the left leg, 5/5 strength in the lower extremities, and no hyperreflexia. X-rays reviewed during this visit showed no significant scoliosis, spondylolisthesis or segmental instability, no compression fractures, and loss of disc height at L5-S1. Hydrocodone and topical medication were prescribed. A plan for physical therapy was noted. Left L4-5 and L5-S1 transforaminal epidural steroid injections were recommended due to good response the last time. I spoke and discussed the case. informed me that the patient had significant pain relief, improvement in function, and decreased medication use status post injection. also informed me that the patient has left-sided weakness at L4-5 myotomes. Although, it was noted that the patient has significant pain relief, there was no information provided in regards to the measurable degree of pain relief. Additionally, there is lack of clear significant neurological findings that are consistent with radiculopathy of the L4-5 and L5-S1 levels. Therefore, the medical necessity of this request is not substantiated.

06/18/2015: Follow-up Visit. We received denial of the patient's L4-5 and L5-S1 selective nerve root block. The patient has undergone previous lumbar decompression surgery. He has undergone this exact injection in the past with good relief. Our goal is to try and maintain conservative, non-operative treatment at this time. He is a candidate for L4-5, L5-S1 selective nerve root block and the patient has documented good response to this injection in the past.

07/15/2015: UR. **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced, this request is non-certified. The percentage of pain relief with previous injection is not documented. There is no dermatomal or myotomal deficits noted. The MRI shows neural foramina are patent at the L4-L5 spinal level.

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

The previous adverse determinations are upheld. It is documented that this patient has had good relief with ESI's in the past for approximately 11 months. However, the percentage of pain relief with the previous injection is

not documented. There was no documentation of a decreased need for medication or improved functional response. The criteria for repeat injections according to ODG is a reported pain relief of at least 50-70% for at least 6-8 weeks. In addition, the most recent physical examination on June2, 2015, fails to clearly document any significant neurological findings that are consistent with radiculopathy of the L4-5 and L5-S1 levels. Therefore, the request for Left L4-L5, L5-S1 Selective Nerve Root Block is non-certified.

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, muscle relaxants & neuropathic drugs).
(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)**