

Health Decisions, Inc.
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Notice of Independent Review Decision

December 9, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left S1 Selective Nerve Block

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

Board Certified Anesthesiologist with over 6 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 male that was injured at work on xx/xx/xx. The claimant has a history of laminectomy with discectomy, ESI and pain medications with no relief.

05-06-09: MRI L-Spine with/without Contrast. Impression: 1. There is a suspected right L4 extraforaminal zone nerve root sheath tumor demonstrating increased signal intensity on T2 – weighted imaging and uniform enhancement post contrast, just in the extra-foraminal zone on the right best seen on axial cuts. 2. Significant right-sided neural foraminal narrowing from disc height loss and facet arthropathy at L4-L5 effecting the right L4 nerve root in the foraminal zone. 3. Mild left-sided neural foraminal narrowing L3-L4. 4. Mild left-sided neural foraminal narrowing at L5-S1.

09-24-09: XR Myelography, Lumbosacral. Impression: Successful fluoroscopically-guided lumbar myelogram at L4.

09-24-09: CT L-Spine without Contrast. Impression: 1. Multiple Intrathecal nodular lesions involving the nerve roots of the cauda equine and along the tip of the conus medullaris. Primary differential consideration would be neurofibromatosis with multiple neurofibromas. This is especially likely given the extraforaminal lesions previously demonstrated by MRI. Further assessment of the patient to include an entire cord screen by MRI imaging as well as a brain study is recommended to assess for the stigmata of neurofibromatosis. Other considerations include diffuse meningeal metastasis. This would be unlikely without a primary malignancy however. 2. The patient is otherwise seen to have degenerative disc disease L2-L3, L3-L4 and L4-L5. These levels result in broad-based disc protrusions, but are without central canal stenosis. The overall affect is felt to be secondary with regards to the nerve root tumors.

08-06-10: Consultation. The claimant c/o low back pain, radicular symptoms, which have been increasing. He had a laminectomy and discectomy done in 2004, which made his symptoms worse at the L4-5 level. He has numbness and weakness in both feet. The claimant rates pain 9/10. He is currently on oxycodone and gabapentin. On exam, there is positive Trendelenburg sign to the right. Decreased reflex on the RLE. Positive seated SLR to 60 degrees on right and 90 degrees on left. Sensation intact. Impression: 1. LBP with radicular sx's d/t herniated disk at the L3-4 and L4-5 with disk space narrowing with internal disk derangement and bilateral foraminal stenosis. Plan/Recommendations: Aqua therapy, dry land therapy, ESI, Lyrica, Zanaflex, Celebrex and Norco.

09-27-10: Physical Medicine and Rehabilitation Consultation. The claimant c/o LBP. Assessment: 1. Rt L4-5 radiculopathy. 2. Prior L4-5 laminectomy/discectomy. Plan: Rt L5 SNB.

10-01-10: Follow up. The claimant is still c/o pain. He will continue medications and will change him over to Flexeril.

10-14-10: Operative Report. Pre-op Dx: L4-5 radiculopathy. Post-op Dx: Same. Procedure: 1. Rt L5 selective nerve block under fluoroscopic guidance without dural puncture. 2. Epidurography. 3. IV conscious sedation.

11-01-10: Follow-up Consultation and Examination. The claimant reports 60-70% improvement from SNB. He still has significant back and buttock pain and some pain in the medial aspect of the both feet. Plan: Repeat L5 SNB.

11-11-10: Operative Report. Pre-op Dx: L4-5 radiculopathy. Post-op Dx: Same. Procedure: 1. Rt L5 selective nerve block under fluoroscopic guidance without dural puncture. 2. Epidurography. 3. IV conscious sedation.

11-29-10: Follow-up Consultation and Examination. The claimant reports 90% improvement. He still has residual back pain. Plan: Continue pain medication.

05-23-11: FUWC. The claimant c/o LBP on the right and radiating to the right buttock. Upon exam, thoracolumbar spine flexion and extension was abnormal.

Tenderness on palpation of the spinous process and SLR of the right leg was positive. The ankle jerk reflex was absent or diminished in both ankles. Assessment: 1. Post-laminectomy syndrome (lumbar). 2. Lumbar radiculopathy at L4-5. Plan: Increase Lyrica.

09-19-11: FUWC. The claimant c/o chronic low back pain radiating to the right ankle. Plan: Continue medication.

02-27-12: FUWC. The claimant c/o a shock-like sensation to the right foot with muscle spasm. He also reports tingling and numbness. Upon exam, thoracic spine has abnormal appearance. Plan: Tramadol added to medication regimen, home exercise program.

11-05-12: FUWC. The claimant c/o LBP midline on the right side, which is excruciating and radiating to the right buttock and posterior leg. Shock like sensation to the right foot and bilateral muscle spasms in the lower back. Assessment: 1. Post-laminectomy syndrome (lumbar). 2. Lumbar radiculopathy at L4-5. Plan: Continue medication regimen.

03-04-13: FUWC. LBP radiating to right foot. MRI Impression: Rt sided based L4-5 disc herniation with moderate rt foraminal stenosis d/t combination of disc herniation and facet hypertrophy. Degenerative disc disease noted in the lower lumbar levels. Plan: Right L5 ESI.

04-11-13: Procedure Report. Pre-op Dx: Lumbar radiculopathy. Post-op Dx: Same. Procedure: Right L5 transforaminal ESI under fluoroscopic guidance w/o dural puncture.

04-26-13: FUWC. The claimant reports 90% relief. Plan: Tramadol, Ultram, Osmotic laser drilled.

08-16-13: FUWC. The claimant c/o pain, numbness/tingling in both feet. LBP on the right radiating to both buttocks. LBP radiating to right posterior leg and foot with muscle spasm. Upon exam, the lumbosacral spine exhibited tenderness on palpation of the spinous process and of the transverse process. Plan: Add Celebrex and Norco, home exercise program.

01-07-14: FUWC. The claimant c/o significant LBP that pain medication is helping.

06-02-14: FUWC. The claimant c/o shock like sensation to both feet with muscle spasm. Upon exam, the thoracolumbar spine flexion was abnormal and extension was abnormal. The lumbosacral spine exhibited tenderness on palpation of the spinous process and of the transverse process. The ankle jerk reflex was absent or diminished in both ankles. A SLR of right leg positive. X-ray Lumbosacral Spine: DDD noted all multiple levels. Moderate to severe foraminal stenosis noted at L4-5, L5-S1.

07-09-14: Procedure Report. Pre-op Dx: Lumbar radiculopathy. Post-op Dx: Same. Procedure: Right L5 transforaminal ESI under fluoroscopic guidance w/o dural puncture.

07-24-14: FUWC. The claimant reports 85% relief. LBP midline radiating to the buttocks, groin, anterior thigh, knee and legs. Plan: Continue pain meds.

10-06-14: FUWC. The claimant c/o LBP flare up. LBP on right and left and radiating to both buttocks, posterior legs, left foot. A shock like sensation from the lower back to the left foot with muscle spasm. A SLR positive on right and left at 45 degrees. Plan: Hold NSAIDS for injection, left S1 SNB.

10-14-14: URA. Rationale: ODG states "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." On 07-24-14, noted in follow-up notes that the patient received 85% relief from the ESI procedure and was doing much better. It is noted that the patient is taking Norco sparingly with Lyrica twice a day, Ultram ER and Celebrex on a regular basis. However, the length of relief is not documented. In addition, ODG states, "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." The patient has a positive objective findings for the S1 radiculopathy on the left with the Achilles reflex being diminished or absent, but the records did not provide imaging findings correlating with the neurological findings. Given all of the above, the requested is not medically indicated within ODG recommendations and not certified.

10-20-14: URA. Rationale: The request for an appeal for Left S1 Selective nerve block is not medically necessary. There is no clear evidence of radiculopathy and clinical exam. There is no MRI or EMG corroborating evidence to support a possible clinical lumbosacral radiculopathy. The guidelines recommended clear clinical evidence of radiculopathy corroborated by EMG and/or MRI studies since proceeding with injection therapy. In this case we do not have any of the above. Therefore, the request for an Appeal for Left S1 Selective nerve block is not medically necessary.

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

The request for an appeal for Left S1 Selective nerve block is not medically necessary. There must be demonstratable evidence of radiculopathy which does not exist on clinical examination. Furthermore, there is no corroborating radiographic evidence (MRI or EMG) to support a possible clinical lumbosacral radiculopathy. Without these, this request for Left S1 Selective nerve block is non-certified.

Per ODG:

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)**