

Medical Assessments, Inc.

4833 Thistledown Dr.

Fort Worth, TX 76137

P: 817-751-0545

F: 817-632-9684

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left L2 Selective Nerve Root Block #1 using Fluoroscopy

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

The Reviewer is a Board Certified Orthopedic Surgeon with over 13 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 female who was injured on XX/XX/XX. She was a XX that was then forward assisting a XX lost balance. She was diagnosed with post-laminectomy syndrome.

XX/XX/XX: MRI Lumbar spine WO contrast. **Impression:** 1. Severe degenerative disc disease is again seen at L2-3 with a broad-based posterior left-sided disc protrusion with moderate canal stenosis and impingement of the lateral recess bilaterally more severe on the left with severe left neural foramina narrowing. 2. There is a mild posterior disc bulge at L1-2, L3-4 and L4-5 without canal stenosis or neural impingement. Bilateral facet arthropathy is seen at L5-S1 with moderate bilateral neural foramina narrowing without canal stenosis.

XX/XX/XX: Office Visit. Claimant is status post left L2-3 laminectomy discectomy with continued pain and parenthesis in the left anterior thigh and leg. Lumbar spine radiographs showing a lumbar curvature, apex at L2-3 with disc space collapse greater at L2-3 and L5-S1.

XX/XX/XX: Office Visit. Claimant is a year out from a laminectomy discectomy done at L2-3 on XX/XX/XX. Claimant reported that she's had no significant symptomatic improvements since the surgery last year. She continues to take medications and do various pain management modalities. She's had some oral steroids that given her some transient symptomatic improvement.

XX/XX/XX: Office Visit. Claimant reported left-sided pain and buttock pain that radiates into the left anterior thigh and hip also is numbness and tingling to the left foot. She reported that she had the symptoms after having had an injury back in XX/XXXX. She states that she had surgery in XX/XXXX which was a lami-disc L2-3. After her surgery she got better but 6 months the pain returned. She has managed the pain with her pain management doctor with Fentanyl patch and Hydrocodone and soma. She has tried Lyrica in the past but had to stop due to

side effects. **Medications:** Levothyroxine, Crestor, Dexilant, Alprazolam, Norco, Fentanyl Patch.

XX/XX/XX: CT Lumbar Spine WO Contrast. **Conclusion:** Degenerative changes with canal stenosis at L2/3.

XX/XX/XX: Operative Report. **Postoperative Diagnosis:** Recurrent disk herniation with hemi collapse of the disk at L2-3 level, status anterior interbody fusion.

XX/XX/XX: Radiology Report. **Impression:** Intraoperative localization

XX/XX/XX: Office visit. Claimant reported she is doing quite well.

XX/XX/XX: Office visit. Claimant reported she is doing well. She's better than she was prior to surgery. She has some stiffness but is better and the leg pain is better as well. She is taking Flexeril, Fenantyl and Percocet. **X-ray:** 2 views of the lumbar spine shows good placement of hardware with no halo, no healing seen just yet.

Assessment: claimant will begin PT. She will continue to wear the brace until she is three months out from surgery. **Status post XLIF 360 on XX/XX/XX, lumbar radiculopathy.**

XX/XX/XX: Office visit. Claimant reported she is doing well with steady improvement of her symptoms. She still has pain when sitting for too long and is able to avoid that. She is progressing in PT. Claimant is to continue PT and to then continue home exercise.

XX/XX/XX: Office visit. Claimant was seen after her XLIF at the 4-5 level. She is well better than she was before surgery, but complaining of some intermittent left leg pain. she did have one episode of right leg pain. The left leg pain though goes to her anterior thigh and radiates to that area. She has much less back pain than she used to have.

XX/XX/XX: MRI Lumbar Spine WO Contrast. **Conclusion:** 1. Left L2-3 pedicle screws and vertical carotid fusion. L2-3 right residual protrusion with mild right foraminal stenosis. 2. Stable degenerative changes elsewhere.

XX/XX/XX: Office visit. MRI showing continued degeneration of the K-1 disk. The 3-4 and 4-5 does look okay. The 2-3 level obviously has had the surgery. There is not severe, but probable foraminal narrowing on the left side greater than right. This may be the source of her anterior thigh pain. **Plan:** Recommended transforaminal injection. The claimant wishes to go ahead with the injections.

XX/XX/XX: UR. Rationale for denial: The claimant is a female who was injured on XX/XX/XX, in a mechanism that is not denoted. The claimant was diagnosed with post-laminectomy syndrome. Treatment has included an L2-3 extreme lumbar interbody fusion on XX/XX/XX, prior lumbar decompression in XXXX and 34 sessions of PT since XX/XX/XX. An evaluation of the claimant on XX/XX/XX noted left leg pain. Objective findings of the lumbar spine and lower extremities were not documented. The most recently documented physical examination findings are from a visit in XX/XX/XX, which included tender surgical incision stable gait and ability to sit conformably. The imaging study did not reveal any L2-3 left-sided nerve compression, as required by the guidelines. The request for a selective nerve root block at L2-3 is not supported. The request for left L5 selective nerve root block #1 using fluoroscopy is not certified.

XX/XX/XX: UR. Rationale for denial: The claimant is a female who was injured on XX/XX/XX. Radiculopathy should be documented on PE and corroborated on imaging studies. The claimant should be initially unresponsive to lower levels of care. A PT note documented an overall decrease in pain with intolerance to activity improving. There was no current physical examination to document radiculopathy. The most recent imaging did not demonstrate any neural involvement on the left. The request for L2 selective nerve root block using fluoroscopy is not certified.

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

The request for selective L2 nerve block is denied.

The patient has completed a L2-3 decompression and fusion following a work accident. She currently complains of pain in the left anterior thigh and hip. She has numbness and tingling in the left foot.

The Official Disability Guidelines (ODG) supports lumbar steroid injections for the patient with objective findings of radiculopathy. Imaging studies and/or electrodiagnostic testing should be consistent with the physical examination findings of nerve compression.

This patient has no evidence of radiculopathy on examination. It is unclear whether the patient's source of pain is localized to the L2-3 disc level. An EMG/NC study is recommended to determine the source of the patient's current complaints, prior to consideration of steroid injections.

The requested injection is not medically necessary at this point in time.

ODG Guidelines:

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)**