

Medical Assessments, Inc.

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar selective nerve root block/Transforaminal ESI left L3

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

The Reviewer is Board Certified in the area of Anesthesiology with over 6 years of experience, including Pain Management

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male that was employed and was injured on XX/XX/XX. He was at work picking up products from the 3rd floor when he started on what appeared to be a pallet. He fell through before reaching the product, hitting metal bars on his way down. He sated the area of injury to be different parts of his back, most his lower back.

XX/XX/XX: Medical Evaluation. **PE:** left leg was swollen, and there is left leg numbness and tingling to the knee, and sometimes the whole foot. Claimant was able to walk on toes and heels without difficulty. Squatting was unable to be performed due to the left side. Standing on one leg was normal. Romberg test was positive e for a backward sway. There was tightness to the paraspinal muscles, mostly on the left. No pain with axial compression. There was tenderness to palpation of the lumbar spine on the left. There was tenderness to palpation of the lumbar spine on the left. There was tenderness to palpation of the left iliolumbar ligament. There was no tenderness to palpation of the coccyx or iliac crests. There was no tenderness to palpation of the sciatic notches. The left trochanter was tender. There was tenderness to palpation of the left thigh and calf. Straight leg rising in the supine was 60 degrees bilaterally, with pain on the right low back, and worse pain on the left low back. Straight leg rising in the seated position was 90 degrees bilaterally, with no pain. Cross straight leg rising was normal bilaterally. Hoover's test was negative bilaterally. Sensation to pinprick and light touch was normal bilaterally. The knee jerks were 0/4 and symmetrical bilaterally. The ankle jerks were 4/4+ and symmetrical bilaterally. No clonus was present. **ROM:** Flexion: 10 degrees, Extension: 10 degrees, Lateral Bending right: 5 degrees, Lateral Bending, Left: 10 degrees. **Muscle Strength:** Muscle strength of the extension of the back was 5/5. Muscle strength of the abdomen was 5/5. Hip flexors 3/5 and left hamstring was 3/5.

Extensors, flexors, invert and everters of the ankles were 5/5 bilaterally. Muscle strength of the great toe extensors and flexors was 5/5 bilaterally. **Waddell's Test:** The claimant has 1 out of 8 positive, which is not a significant for symptom magnification. **Diagnosis:** 1. Lumbar strain/sprain 2. Thoracic strain/sprain. 3. Lumbar herniation at L4-5.

XX/XX/XX: MRI Thoracic Spine without contrast. **Conclusions:** 1. Minimal dorsal bulging, T1-T2. 2. Evidence suggestive of dorsal bulge-herniation partially visualized at C5-C6. MRI of the cervical spine is recommended for further, more accurate assessment. 3. No acute or aggressive bone or marrow lesion identified. No evidence of abnormal masses or signal changes within the visualized spinal cord or conus medullaris. No significant stenosis or specific neural compromise observed in the thoracic spine at this time.

XX/XX/XX: MRI Lumbar Spine without Contrast. **Conclusion:** 1. Active right foramina-far lateral 2-3 mm protrusion creating corresponding neural foramina stenosis and ipsilateral exiting nerve root encroachment-mass L4-L5. Recommend clinical correlation for associated posttraumatic right L4 radicular involvement. 2. Facet joint effusion L4-L5 and L5-S1 combined with evidence of L4-L5 active annular fissure. These changes, which may have been propagated and/or aggravated by the reported injury, are suggestive of active inflammatory processes and have been implicated as clinical pain generators creating radicular type symptoms and or focal pain. Clinical correlation is advised. 3. Suspected hypolordosis. Clinical and weight-bearing radiographic correlation advised for posttraumatic my spasm, articular dysfunction and/or abnormal spinal biomechanics. 4. No acute or aggressive bone or marrow lesion identified. No evidence of abnormal masses or signal changes within the conus medullaris or occluded distal thoracic spinal cord.

XX/XX/XX: Office notes. **X-ray:** Lumbar spine show mild diminished distress height at L5-S1 flexion extensions do not show instabilities, cone down lateral in intact AP radiograph shows pedicles are intact. Sacroiliac joints are intact, date XX/XX/XX.

XX/XX/XX: Office notes. **Current Medications:** Soma 350mg, TID PRN pain, Norco 10-325mg. The claimant has suffered for greater than 2 weeks from radicular symptoms despite conservative measures including PT, NSAID's, muscle relaxants that have failed to control symptoms. The claimant has documented findings on examination supporting a radicular pathology. MRI findings are consistent with stenosis, either central, lateral recess or foramina, likely to cause radicular pathology. There are no positive Waddell's sign or evidence of psychosocial pathology that would preclude performance of the recommended transforaminal injection procedure.

XX/XX/XX: UR. Rationale for denial: The claimant is XX year old male associate with an injury date of XX/XX/XX. He developed back pain after harness catching him falling through a pallet. Left lower extremity numbness is reported. He has undergone PT and medication management without improvement. While the ESI is medically reasonable, the monitored anesthesia is not supported. However, as I was unable to reach the doctor to modify the request, the entire request is not recommended as medically necessary. Based on my review of the submitted medical documentation, the request for Lumbar selective nerve root block/Transforaminal ESI left L3 with fluoroscopy and monitored anesthesia is not medically necessary.

XX/XX/XX: UR. Rationale for denial: The claimant sustained a work related injury. The claimant had PT. An MRI showed a right L4-5 facet joint effusion with right L4 compression. The claimant has a left straight leg raise and reduced left patellar reflex on exam. He has no medical or psychiatric issues per the XX/XX/XX consult. Appeal lumbar selective nerve root block/transforaminal epidural steroid to left L3 with fluoroscopy and monitored anesthesia is not medically necessary.

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

The previous determination has been partially overturned. The claimant is a male associate with an injury date of XX/XX/XX. He developed back pain after harness catching him falling through a pallet. Left lower extremity numbness is reported. He has undergone PT and medication management without improvement. An MRI showed a right L4-5 facet joint effusion with right L4 compression. The claimant has a left straight leg raise and reduced left patellar reflex on exam. He has no medical or psychiatric issues per the XX/XX/XX consult. While the ESI is medically reasonable, the monitored anesthesia is not supported. Therefore, the lumbar selective nerve root block/transforaminal epidural steroid to left L3 with fluoroscopy is certified but the monitored anesthesia is not medically necessary.

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)