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Notice of Independent Review Decision

**Date: December 28, 2012**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Repeat selective nerve root block to right L5 with sedation using CPT 64483 and 99144

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

Board Certified Orthopaedic surgeon

**REVIEW OUTCOME:**

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Office visits (07/19/11 – 11/15/12)
- Diagnostics (07/22/11 – 11/08/12)
- Surgery (10/26/11 – 07/12/12)
  
- Office visits (07/25/11 – 11/15/12)
- Diagnostics (04/17/12)
- Surgery (07/12/12)
- Utilization reviews (11/21/12, 12/06/12)

**TDI:**

- Utilization reviews (11/21/12, 12/06/12)

ODG has been utilized for the denials.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who injured his lower back on xx/xx/xx. He was bending over to pick up a box from the floor and felt extreme low back pain. By the end of the night, he ended up having to go to the emergency room (ER) because the low back pain was so bad and he was unable to walk.

**2011:** On July 19, 2011, the patient was evaluated for popping and pain shooting down both sides of the buttocks. The patient had been seen at NTMC where he underwent x-rays. The patient reported that he would hurt most when lying down. The pain was radiating to the bilateral legs. Examination revealed tenderness in the lumbar paraspinal muscles, decreased range of motion (ROM) and inability to bend forward. The evaluator recommended continuing treatment from the ER and obtaining magnetic resonance imaging (MRI) of the lumbar spine.

On July 22, 2011, MRI of the lumbar spine showed disc desiccation and mild loss of disc height at T12-L1 with mild anterior endplate spurring and small Schmorl's node involving the inferior endplate of T12. There was a small central disc protrusion measuring 3 mm in the AP dimension indenting the ventral thecal sac but not causing spinal stenosis or neural foraminal stenosis. There was mild desiccation without loss of disc height at L3-L4 with mild anterior endplate spurring and mild diffuse disc bulge measuring 2-3 mm in the AP dimension with bilateral facet and ligamentum flavum hypertrophy. There was mild spinal stenosis with the thecal sac measuring 8 mm in the AP dimension and mild right-sided foraminal stenosis. There was mild bilateral facet arthropathy at L4-L5. There was central disc protrusion measuring 4 mm in the AP dimension at L5-S1 with T2 high intensity zone along the posterior disc annulus in the midline consistent with a small annular fissure indenting the ventral thecal sac.

On July 25, 2011, the patient was evaluated for follow-up of injury to low back. The evaluator noted increased ROM with exercises. The patient was utilizing medications prescribed at the ER. He prescribed Ultracet and prednisone and referred the patient to a neurosurgeon for evaluation and possible epidural steroid injection (ESI).

On August 1, 2011, evaluated the patient for low back pain. The patient reported that his symptoms included excruciating pain, stabbing in quality, with radicular symptoms into both legs. The radicular symptoms, numbness and achiness would go down the back of the legs and stop around the heel. He had difficulty walking due to his symptoms. He also had difficulty with bowel and bladder since the incident. The patient was urinating more often and had lost control of urine several times and that he had difficulty and pain with defecation. History was positive for depression and bipolar disorder. Examination revealed tenderness of the paraspinal muscles of the lumbar area, inability to flex the extensor hallucis longus on the right foot and inability to raise the right foot and the anterior tibialis. The patient was unable to straighten his leg completely on the right side. reviewed the MRI and recommended physical therapy (PT) and ESI.

From August through September, the patient attended eight sessions of therapy with 50% improvement in his symptoms.

On September 28, 2011, noted that the patient had completed therapy and was doing better but then they started decompression and the patient had worsening of his symptoms. He reported pain all the time and inability to move around. The symptoms were going all the way down the right leg and included crampiness and extreme amounts of pain all the time. There was achiness, numbness, pins and needles and burning pretty consistently. Examination revealed an antalgic gait, weakness, and unwillingness to push against resistance at the anterior tibialis, extensor hallucis longus, gastrocsoleus and inability to straighten the right leg secondary to the pain, which would be a positive straight leg. There were changes in sensation of the right leg in all areas in comparison to the left. diagnosed lumbar radiculopathy and herniated nucleus pulposus (HNP) at L5-S1 on the right side. He prescribed pain medications including tramadol, Mobic and Lyrica and recommended a lumbar ESI.

On October 26, 2011, performed an ESI at L5-S1 on the right.

On November 30, 2011, noted that the injections helped only for the first couple of weeks. The symptoms were back as bad as before. Examination showed tremulousness on both sides with sitting root test on the right side mildly reproducing pain. reviewed the MRI and recommended laminectomy/discectomy.

2012: On January 6, 2012, performed micro-hemilaminotomy and partial discectomy at L5-S1 on the right.

On January 23, 2012, noted that the patient was doing well from the standpoint of marked improvement of his lower extremities complaints. He was having a little bit of achiness in the back. recommended postoperative PT and recommended weaning off of his medications.

On February 1, 2012, the patient underwent therapy evaluation and was recommended therapy consisting of manual therapy, therapeutic exercise, HEP instruction, AROM/PROM exercise, posture/body mechanics, neural mobilization, spinal stabilization and gait training.

On March 1, 2012, noted that the patient had more of the symptoms down the right leg just like it was before the surgery. The symptoms would come and go. He reported that when he stopped tramadol and took just the hydrocodone he felt pretty good and had relief of symptoms. He had nine sessions of the therapy left. Examination showed normal gait pattern and slight decrease of the right gastrocsoleus. started the patient on some Protonix and refilled hydrocodone and Lyrica. He recommended stopping tramadol and Mobic and obtaining a functional capacity evaluation (FCE) to see if the patient would be started on work conditioning.

On March 21, 2012, noted increasing symptoms. The patient reported that he was feeling horrible pains down the back of the right leg and down the left leg with extreme amount of low back pain. The patient reported that he was depressed.

Examination showed antalgic gait pattern, positive straight leg raising (SLR) on the right with weakness of the right quadriceps, anterior tibialis, extensor hallucis longus. assessed status post laminectomy/discectomy at L5-S1 on the right. He ordered new lumbar MRI with and without contrast and recommended evaluation by for conservative measure and possible treatment of depression and other symptoms.

On April 17, 2012, MRI of the lumbar spine showed postoperative changes at L5-S1 related to right laminectomy with no evidence of persistent or recurrent disc protrusion, prominent enhancement of granulation tissue at the operative site and surrounding the right nerve root, mild degenerative changes in the lumbar spine at L3-L4 and L4-L5, degenerative changes in the lower thoracic spine impacting the lower thoracic spinal cord at T11-T12.

On May 23, 2012, noted right-sided low back pain and right leg pain which was constant. The patient was utilizing Lyrica and Norco. He had tried Flexeril in the past with no improvement. Examination revealed decreased sensation to the anterior and lateral thigh as well as lateral calf, tenderness and spasm to the lumbar paraspinal musculature, slightly limited ROM, soreness with ROM but no pain radiating down the legs, positive SLR on the right, pain going down the left leg but more of tightness. was unable to elicit Achilles reflex. The patient complained of pain and discoloration in his feet. There was tenderness on the medial malleolus and just posterior to that. recommended therapy and an evaluation by the family doctor regarding urinary symptoms. He added Zanaflex and continued Lyrica and Norco.

On June 26, 2012, evaluated the patient for leg pain located on the right side. The patient reported intermittent subjective weakness. Examination revealed balanced gait, nonpainful lumbar ROM except with flexion which was limited and positive SLR on the right side at 45 degrees. There was mild-to-minimal weakness in the dorsiflexors and extensor hallus longus. obtained electromyography/nerve conduction velocity (EMG/NCV) study, which was unremarkable. recommended a right L5 selective nerve root block.

On June 29, 2012, per PT discharge summary, the patient had attended six sessions of therapy and was feeling a little better.

On July 12, 2012, performed selective nerve root block at L5 on the right side.

On August 23, 2012, noted back pain and leg pain located on the right side. The patient reported that the injections helped with the leg pain but not with back. A designated doctor who opined that the patient was not at MMI saw the patient. Examination revealed mild-to-minimal weakness in the dorsiflexors and extensor hallus longus and dysesthesia over the anteromedial lower leg on the right. assessed recurrent radicular pain following discectomy and sciatica. He noted that the treating doctor would not see the patient anymore because he was a Worker's Compensation patient.

On November 6, 2012, the second postoperative MRI of the lumbar spine showed postoperative changes at L5-S1 without evidence of persistent recurrent disc protrusion, prominent enhancing granulation tissue at L5-S1 surrounding the right nerve root, degenerative disc in lower thoracic spine with disc at T11-T12 contacting the thoracic spinal cord, mild degenerative changes in the mid lumbar spine with borderline spinal stenosis accentuated by the patient's congenitally short pedicles.

On November 15, 2012, noted back pain and leg pain located on the right side. The patient had worsening pain to the back and to the posterior right leg. There was burning at the tailbone with sitting. Examination showed an obese patient with tenderness on the right and spasms bilaterally, painful flexion and extension, tenderness at the spinous processes in the lower region and normal SLR bilaterally. recommended selective nerve root block at L5 on the right side.

Per utilization review, dated November 21, 2012, the request for selective nerve root block was denied with the following rationale: *"The request for repeat selective nerve root block to the right L5 with sedation, using CPT codes # 64483 and # 99144 was not medically necessary. The patient has no radicular findings on his exam to support a nerve root block. The patient had this injection in July with a follow-up note done six weeks later that indicated it helped his leg pain. However, in light of no positive leg or radicular findings on his objective exam, an ESI of any type is not supported as per ODG."*

On December 4, 2012, a request for reconsideration of injection was submitted.

Per a reconsideration review dated December 6, 2012, the appeal for selective nerve root injection was denied with the following rationale: *"The patient has no objective radicular findings such as reflex, motor or sensory changes that correspond to a specific nerve root. The patient had an ESI in July with reduction in leg pain. However, there was no percentage of improvement noted. There was recurrent pain but no positive objective radicular findings on exam. Therefore, repeat injection is not supported per evidence-based guidelines. The request for a repeat selective nerve root block to right L5 with sedation, using CPT codes #64483 and #99144 is not medically necessary."*

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

**The denials were appropriate, based on published ODG criteria.**

**ODG criteria are as follows:**

**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 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.)

**The criteria for the establishment of the clinical diagnosis of radiculopathy is as follows:**

**[Andersson GBJ, Cocchiarella L, American Medical Association. Guides to the Evaluation of Permanent Impairment, Fifth Edition. Hardcover - Dec 15, 2000.](#)**

### **Radiculopathy** (page 382-383)

“is defined as significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness, and/or paresthesias in a dermatomal distribution. A root tension sign is usually positive. The diagnosis of herniated disk must be substantiated by an appropriate finding on an imaging study. The presence of findings on an imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be clinical evidence as described above.”

### **Electrodiagnostic evidence of acute nerve root pathology** (page 382-383)

“includes the presence of multiple positive sharp waves or fibrillation potentials in muscles innervated by one nerve root. However, the quality of the person performing and interpreting the study is critical. Electromyography should be performed only by a licensed physician qualified by reason of education, training, and experience in these procedures. Electromyography does not detect all compressive radiculopathies and cannot determine the cause of the nerve root pathology. On the other hand, electromyography can detect noncompressive radiculopathies, which are not identified by imaging studies.”

Rating: 9a

### Radiculopathy, page 382-383:

#### Weekly Impairment Evaluation Tip-Radiculopathy

The preferred methodology in the AMA Guides 5th ed. for rating impairment of the spine is the Diagnosis- Related Estimate (DRE). Table 15-3, Criteria for Rating Impairment Due to Lumbar Spine Injury, Table 15-4, Criteria for Rating Impairment Due to Thoracic Spine Injury, and Table 15-6, Criteria for Rating Impairment Due to Cervical Disorders, outline the five applicable categories and impairment ranges based upon historical, physical examination, and other clinical findings. Box 15-1, Definitions of Clinical Findings Used to Place an Individual in a DRE Category, on pages 382-383 contains essential definitions of clinical findings to help assess the proper placement of an examinee in a DRE category. In our experience, after reviewing thousands of reports over the past years, the diagnosis of Radiculopathy presents one of the more challenging concepts when determining the correct DRE placement. The Guides define Radiculopathy as a "significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots". The most important clinical components required to support the diagnosis of a compressive Radiculopathy include:

- Pain, numbness, and/or paresthesias in a dermatomal distribution
- An imaging study documenting correlating concordant nerve root pathology
- Associated clinical findings such as loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle groups, loss of sensation in the corresponding dermatome(s)

Electrodiagnostic studies are helpful in supporting the diagnosis of a compressive radiculopathy but are not required, and do not substitute for imaging studies.

Impairment Tip Archives at [www. impairment.com/tips](http://www.impairment.com/tips)

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR  
OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**