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May 27, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Epidural pain block of L4-L5 (64483, 64484)

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

Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME:

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

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury on xx/xx/xx. The patient was washing the floor as she walking and slipped and fell, hitting the left side of face and upper back.

2014: The patient underwent a functional capacity evaluation (FCE) on April 21, 2014. It was noted the patient had undergone 12 to 18 sessions of physical therapy (PT). The patient then consulted VDNC on April 18, 2014, and was diagnosed with contusion of the cervical and thoracic spine. During the FCE, the patient qualified as Light physical demand level (PDL) versus the Medium category required by her job. The evaluator recommended a magnetic resonance imaging (MRI) of the low back and head.

A lumbar MRI performed on May 12, 2014 revealed the L4-L5 level had moderate narrowing of the disc space and decreased signal of the disc indicative of dehydration and desiccation. There was also a broad based posterior protrusion disc herniation in the central and lateral aspects bilaterally with facet arthropathy. There was indication of slight to moderate inferior neural foramina1 stenosis bilaterally. At L3-L4, there was a broad-based posterior protrusion-subligamentous

disc herniation more prominent posterolaterally measuring 4.5 to 4.8 mm in AP diameter and indenting the thecal sac. Facet arthropathy was present and there was slight moderate inferior neural foraminal stenosis bilaterally. At L5-S1, there was a broad-based posterior protrusion-subligamentous disc herniation measuring 3 to 3.3 mm in the AP diameter, slightly indenting the thecal sac. Facet arthropathy was present and there was slight inferior neural foraminal stenosis bilaterally.

An electromyography/nerve conduction velocity (EMG/NCV) study performed on June 18, 2014, revealed a normal study with no evidence of right or left lumbar or sacral radiculopathy, lack of bilateral lumbosacral plexopathy, lack of bilateral sciatic mononeuropathy or lack of sensory or motor polyneuropathy.

On June 23, 2014, the patient was evaluated for injury involving the left side of head, neck, upper back and mid back. The pain level was 6/10. The diagnoses were contusion of face and neck, sprain/strain of thoracic and lumbar spine and neck sprain/strain. The patient was given injection Toradol, prescription for naproxen and referral to pain management.

pain management, evaluated the patient on July 1, 2014, for neck pain. The patient reported at the time of the injury, she had lost consciousness for about 10 minutes. She was taken to the where she underwent x-rays and computerized tomography (CT) scan of the head. The patient now reported weakness in the lower back with radiating pain down the legs worse on the right. On examination of the lumbar spine, there was mild paraspinal tenderness, decreased range of motion (ROM), diminished patellar reflexes, deficits associated in the L4-L5 and L5-S1 dermatomal pattern. The diagnoses were back pain, lumbar radiculopathy and lumbar disc disease.

On July 30, 2014, the patient underwent a lumbar epidural steroid injection (ESI) at L4-L5.

In a designated doctor evaluation (DDE) on August 1, 2014, opined the patient was not at maximum medical improvement (MMI) as she should have an evaluation and treatment for the radiculopathy that appeared to be present on the right at S1, which could be confirmed with electrodiagnostic testing and treated with pain medicine. The extent of injury would specifically include the disc herniations at either L4-L5 or L5-S1 as being significant enough to cause the right plantar reflex absence. The disc herniations at L4-L5 and L3-L4 and the bulging at L2-L3 were of uncertain significance. Kidney stones were not work-related.

In a follow-up on August 13, 2014, the patient reported the ESI she received on July 30 did not help to alleviate her pain. prescribed tramadol for relief of pain.

A Psychosocial Evaluation on September 17, 2014, revealed the patient had a depressed mood, was coherent, had intact memory, intact remote memory, denied any delusions or hallucinations. Beck Anxiety Inventory score was 53, indicating extreme anxiety, and her Beck Depression Inventory of 30 indicated severe depression. The patient's Axis I indicated major depressive disorder; Axis III

revealed lumbar radiculopathy, lumbar disc disease, and lumbar pain; Axis IV revealed severe psychosocial stressors due to unemployment, finances, interpersonal issues, and chronic pain; and Axis V GAF score was indicated to be 55, whereas prior to injury score was 90. The patient had severe depression, anxiety, and pain affecting her normal physical, psychosocial, vocational, and interpersonal functioning, which interfered with her activities of daily living (ADLs).

On October 23, 2014, noted the patient had worsening of her low back and neck pain, with a pain score of 8/10. The low back pain radiated down the back of her right leg with associated weakness. She also reported a numbness sensation to the hands. The patient reported she developed fever due to the pain. She had loss of memory and was forgetting things, felt dizzy, and weakness to her legs about 10 days ago. prescribed Neurontin and allowed the patient to return to work with restrictions. Psychological counseling was recommended due to patient being emotionally distraught.

On October 30, 2014, diagnosed cervicalgia/sprain, lumbago/sprain and head trauma with loss of consciousness. He prescribed ibuprofen and referred the patient to a neurologist.

On November 5 2014, and November 19, 2014, noted moderate lumbosacral tenderness, moderate decreased flexion and extension, right and left lateral flexion at 40 degrees. Straight leg raising (SLR) test bilaterally showed moderate pain at 60 degrees to the back. The Achilles reflex was decreased on the right. There was decreased dorsiflexion of the foot, decreased knee extension with resistance, evidence of radiculopathy and decreased sensation to the lateral aspect of the foot. requested a lumbar ESI at the L5-S2 level to decrease her low back pain and radiculopathy. The patient was placed off work and a request for individual counseling was made.

On December 4, 2014, noted severe tenderness at the lower lumbosacral joint, decreased ROM upon flexion and extension, positive SLR test at 5 degrees, decreased distal sensation at the lower left leg and an antalgic gait. The patient was unable to perform Patrick's sign and Kemp's sign due to pain. The patient to continue OTC ibuprofen and was restricted from all work. A transcutaneous electrical nerve stimulation (TENS) unit was prescribed on a trial basis.

2015: On January 21, 2015, noted the claimant had constant low back pain centered in the back and radiated to the inguinal region. Pain level was 10/10 on the VAS scale. The patient continued with headaches and neck pain that increased by the end of the day. The patient was continued on Tylenol #3 and was given a prescription for Zoloft for relief of anxiety.

In a neurosurgical evaluation, evaluated the patient on January 29, 2015, for pain in the lower back that went to the hips, buttocks that radiated to the right groin region and both legs. The patient stated pain was severe and resistant reviewed the MRI and recommended a facet block at L4, L5, and S1 as ESIs had not helped.

On February 4, 2015, noted the patient was currently off work due to her worsening symptoms. The patient reported she had been working light duty since her injury and tried to do her best. stated pain, depression and anxiety were often interwoven. Zoloft was medically necessary and would be helpful with episodes of insomnia. He felt the patient was an ideal candidate for a work hardening program (WHP) since her pain levels had significantly decreased with the injection.

On February 9, 2015, the patient complained of a lack of sleep and had sun out of her pain medications, indicating the pain level to be at 9/10 with continue pain to the right side with burning radiating down to her right hip and leg, and indication of weakness sometimes and giving out. The patient's Beck Anxiety Inventory score was currently a 45 and Beck Depression Inventory score was currently a 44. Per , the patient was not making improvements in individual counseling and she would be recommended for a more intense form of therapy.

An FCE performed on February 12, 2015, revealed the patient's PDL was negligible and that was unable to perform required testing due to restricted right upper extremity and low back range of motion, severe weakness in the right shoulder, and neck and low back pain. The documentation indicated that the employer's PDL requirement was at medium. The patient reported a pain scale of 6/10 in the neck, right shoulder, right foot, and low back. The examination of the thoracolumbar spine revealed moderate tenderness and muscle spasms upon palpation. Neurological testing revealed upper extremity reflexes were equal and reactive bilaterally with normal sensation. The lower extremity reflexes were decreased. The patient denied performing heel and toe walk. The outcome of the Functional Capacity Evaluation indicated the patient was functioning at a negligible PDL.

In follow-ups on February 12 2015, and February 26, 2015, noted the patient had tried PT, activity modification, home exercises and medications and had no improvement. He therefore recommended an epidural pain block of L4-L5-S1.

Per a utilization review dated February 27, 2015, the request for an epidural pain block at L4-L5 was non-certified. Rationale: *"The following conditions were found to be compensable: Disc herniation at L4-L5, disc herniation at L5-S1, lumbar sprain/strain, thoracic sprain/strain, cervical sprain/strain, right foot contusion head contusion, left hip sprain/strain and the additional conditions listed were found to be not compensable: Kidney stones, posterior bulging disc at L2-L3, disc herniation at L3-L4 and prolapsed uterus. The compensable work February 19, 2014, is neither a producing cause of, nor an aggravation at these conditions, which are ordinary diseases of life. disputes that the incident on February 19, 2014, resulted in any compensable lost time. Our file indicates lost time is seven days and that you have returned to work as of March 2, 2014, earning your pre-injury wage. To be compensated, you must have exceeded seven days and that once you return to work that you are working in a reduced capacity. will continue to evaluate any new information and reserves the right to amend its position accordingly."*

On March 3, 2015, noted the patient had persistent back pain, with pain score of 5-6/10. It was noted the patient had six weeks of PT with some improvement. The

patient stated she was having financial strains with her current income and was eager to return to work. re-submitted the request for a WHP.

On March 12, 2015, noted ongoing pain to the mid and low back with radiation to the right leg down to the right foot. The patient stated she had numbness and weakness of her legs. She stated she had pain to the neck as well. recommended the patient to take tramadol and have PT for the upper extremities for two weeks for three sessions per week. An epidural pain block at L4-L5 was recommended due to low back pain radiating to the legs with numbness and weakness and weakness of the legs.

On March 26, 2015, the patient continued with complaints of head, neck and low back pain. The patient reported difficulty walking due to the pain and was unable to sit or stand for long due to pain in the right hip, low back and right leg. She reported throbbing pain on the left lower abdominal and inguinal region. Pain was rated as 9-10/10. She was taking tramadol three times a day and was having difficulty sleeping due to increased pain in the past three months. Examination noted tenderness to the L2-L5 region, sensation was decreased on the right leg on L4-L5 with tingling and lumbar radiculopathy. Range of motion was decreased in the cervical, thoracic and lumbar spine on flexion, extension, and lateral rotation, Straight leg raise was 80 degrees on the right leg and 80 degrees on the left leg. Facet block of L4-L5-S1 was recommended.

According to a utilization review dated April 16, 2015, the appeal for an epidural pain block at L4-L5 was non-certified. Rationale: *“Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is Non-Certified. Based on the post-procedure pain report, the patient did not obtain at least 50 percent improvement following the epidural steroid injection. There was no documentation establishing that the patient had at least 6-8 weeks of efficacy from the epidural steroid injection, reduction of pain medication use, or functional improvement to support the request as medically necessary.”* Reviewer’s Comments: *“This is an appeal of a previous denial in which the prior reviewer noted lack documentation regarding continued objective pain relief, functional response, and decreased need for pain medications to support repeat epidural steroid injection. The request includes CPT codes for epidural steroid injections at two levels. The clinical report from recommended an epidural steroid injection at one level only. The patient is noted to have had a prior lumbar epidural steroid injection at L4-5 performed on July 30, 2014. There was a post-procedural report dated August 13, 2014, at which the patient reported a pain score at 5/10 following the epidural block. The patient's pain level before the block was reported as 7/10. March 12, 2015, clinical report still does not discuss the extent of relief obtained with the epidural steroid injection. Per guidelines, there should be at least 50-70 percent relief of pain following epidural steroid injections for 6-8 weeks in order to support repeat injections. Based on the post-procedure pain report, the patient did not obtain at least 50 percent improvement following the epidural steroid injection. There was no documentation establishing that the patient had at least 6-8 weeks of efficacy from the epidural steroid injection, reduction of pain medication use, or functional improvement to support the request as medically*

necessary. Therefore, this reviewer would not recommend certification for the appeal request at this time.”

On 04/02/2015, noted generalized tenderness to the right L4-L5-S1 region, decreased sensation on the right leg on the right L5-S1 tract. Range of motion was decreased in the lumbar spine on flexion, extension and lateral rotation. Straight leg raise was 30 degrees on the right leg and 70 degrees on the left leg. Epidural pain block of L5-S1 was recommended.

The patient reported she had two more sessions of physical therapy left on April 23, 2015. She reported pain in the low back radiating to the right groin, thigh, knee, leg, calf and foot. She also reported pain in the mid back that went up to the neck, right arm, shoulder and right arm. The patient reported the physical therapy had not helped and she felt worse after the session. The patient was unable to lay on her right side due to pain. Examination noted severe right radiculopathy, decreased sensation on the right L4-L5-S1 dermatome, straight leg raise 30 degrees on the right and 70 degrees on the left. Epidural pain block of L4-5 was recommended.

On May 21, 2015, noted examination remained the same. The patient reported no improvement in her pain. Epidural pain block L4-L5 was recommended.

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

The patient has an L45 HNP with neurological findings which support the diagnosis of radiculopathy. The Epidural injection proposed is well within the ODG guidelines based on the records provided.

All of the following criteria were met in this patients records:

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:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES