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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 5/25/16

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Selective Nerve Root Block (CPT code 64483, 64484, 01992)

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

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

I have determined that the requested Lumbar Selective Nerve Root Block (CPT code 64483, 64484, 01992) is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker is a male X who sustained an industrial injury on XX/XX/XX. Injury occurred when he fell 6 feet onto his back and left leg. Conservative treatment included medications, activity modification, epidural steroid injections, and physical therapy. The XX/XX/XX orthopedic report documented that the injured worker had some epidural steroid injections in XX/XXXX with 100% post block anesthetic relief, but pain severely increased 3 days following the injections. The X/X/XX lumbar spine magnetic resonance imaging (MRI) findings documented 7 mm of left foraminal and extraforaminal disc herniation at lumbar (L) 3/4 with moderate to marked left foraminal narrowing and compression of the left L3 nerve root and left sided ganglion. At L4/5, there was 4 mm of left posterior lateral, foraminal and extraforaminal disc protrusion compression the ganglion and left L4 nerve root laterally. There is mild to moderate foraminal stenosis, mild central canal narrowing with facet and ligamentum flavum hypertrophy, degenerative change, and grade 1 retrolisthesis. The XX/XX/XX initial

spine surgery report cited complaints of constant low back pain radiating into the left lateral hip and thigh with associated weakness, numbness and tingling. Symptoms were worse with standing and walking, and better with sitting and medications. Physical therapy based modalities had previously improved symptoms. Lumbar injections (type unknown) and tramadol had failed to provide symptom relief. Current medications included Tylenol or Aleve. He was unable to continue taking gabapentin due to side effects. Neurologic exam documented decreased left L3 and L4 dermatomal sensation, absent left patellar and bilateral Achilles reflexes, no lower extremity weakness, and positive straight leg raise on the left. Physical exam documented slow and guarded gait, bilateral lower lumbar paravertebral muscle tenderness, and painful lumbar flexion. The diagnosis included radiculopathy secondary to lumbar disc displacement left L3, L4, and L5 levels. Authorization was requested for lumbar selective nerve root blocks/transforaminal epidural steroid injection at left L3, L4 and L5 with anesthesia. The X/X/XX peer-review non-certified the request for lumbar selective nerve root blocks/transforaminal epidural steroid injections at left L3, L4, and L5 on the basis that there was no documentation of objective 50-75% pain relief for 6-8 weeks with prior epidural steroid injection, lack of recent exhaustion of conservative treatment, and no documentation to support the need for injection at more than 2 nerve root levels.

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

The Official Disability Guidelines (ODG) support the use of epidural steroid injections as an option for the treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Criteria include radiculopathy documented by physical exam and corroborated by imaging studies and/or electrodiagnostic studies and the patient should have been unresponsive to conservative treatment. No more than two nerve root levels should be injected using transforaminal blocks. Repeat blocks may be supported if initial blocks are found to produce pain relief of at least 50-70% for at least 6-8 weeks. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

Guideline criteria have not been met in this case. This injured worker presents with low back pain radiating into the left lateral thigh with associated weakness, numbness and tingling. Clinical exam findings are consistent with radiculopathy and corroborated with imaging evidence of nerve root compromise at the L3/4 and L4/5 levels. Evidence of long-term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, records documented limited response to prior epidural steroid injections without sustained benefit consistent with guideline criteria to support repeat injections. Additionally, a 3-level block is requested which is not consistent with guidelines. Therefore, this request is not medically necessary.

Therefore, I have determined the requested Lumbar Selective Nerve Root Block (CPT code 64483, 64484, 01992) is not medically necessary for treatment of the patient's medical condition.

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)