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DATE: 6/4/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Selective Nerve Block at Left L3-4

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by The American Board of Anesthesiology with over 11 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]:
XXXX. Claimant c/o bilateral lower extremity and left lower extremity pain greater than the right.

XXXX: MRI Lumbar Spine WO. T12-L1: Disc desiccation of the disc with anterior spondylosis loss of height of disc. 3mm posterocentral broad-based subligmentous disc herniation indenting the ventral thecal sac. L1-2: Disc desiccation with loss of height of disc. 2.3 posterocentral broad-based subligmentous disc herniation indenting the ventral thecal sac. Moderate anterior spondylosis. L2-3: Disc desiccation of the disc with endplate sclerosis. 2mm posterocentral broad-based subligmentous disc herniation indenting the ventral thecal sac. Bilateral facet hypertrophy left more than right. Impingement of the left exiting nerve and neural foramina. L3-4: Desiccation of the disc. 4mm left paracentral and left lateral disc protrusion/herniation. It is broad-based. Bilateral facet hypertrophy. Central spinal stenosis with AP diameter measuring 8mm. Moderate left foraminal stenosis and impingement of left exiting nerve in neural foramina. L4-5: Desiccation of the disc with 4mm posterocentral broad-based subligmentous disc herniation indenting the ventral thecal sac. Bilateral facet hypertrophy. Bilateral foraminal stenosis and bilateral impingement of exiting nerves in neural foramina left more than right. Moderate central spinal stenosis with AP measuring 6mm. L5-S1: Disc desiccation with loss of height of disc. 3mm posterocentral broad-based subligmentous disc herniation indenting the ventral thecal sac. The herniated disc lateralizes bilaterally. Bilateral foraminal stenosis left more than right. There is bilateral impingement of exiting nerves and neural foramina left more than right. Central spinal stenosis with AP diameter measuring 9mm.

XXXX: Initial Consult with XXXX. BLE pain, left greater than right. Pain is located in bilateral lower lumbar paraspinal region and left is greater than right. Aching and sharp. Pain is constant and varies in intensity. Pain in low back and LLE is made worse by walking, getting up from sitting position, lifting, twisting, lumbar extension, standing and pulling. Pain is made better by rest, sitting, changing positions, ice compresses, medications and flexion. Pain is worsening from initial onset. LLE pain is noted in the

left groin and anterior and posterior thigh and numbness is noted in the foot distally. LLE symptoms are aching, shooting, dull and sharp. It is present and varies in intensity. Order: LESI x 3, activity modification and PT program. The pt has had 6 weeks of conservative care prior to today's visit including but not limited to PT, medications, and activity modifications without improvement. Pt reports abdominal pain and numbness associated with the pain. Pain average: 5-/10, worst: 4/10 and present: 4-5/10. Hx of but never treated for Depressive Disorder. Medications: XX 2mg, XX 40mg, XX 220mg, XX 50mg, XX 40mg, XX 500mg, XX 20. Pinprick sensation decreased: Bilateral L3 and L5 and Left L4. Give-way weakness present in LLE. Heel-Toe walking, normal. Gait is antalgic and slow & guarded. Straight leg raise: L-positive while seated for radiating leg pain and bilaterally for low back pain. Waddell's sign not present. Point of maximal tenderness: bilateral lower lumbar paravertebral and bilateral gluteal. ROM normal in flexion, extension, rotation and lateral bending despite pain with flexion. ROM limited in extension by pain. DX: Disc disruption without myopathy: Central L2-3, Central L3-4, Central L4-5, Central L5-S1. Lumbar spinal stenosis with radiculitis/radiculopathy-moderate. Lumbar disc displacement with radiculopathy- right L2, Left L5, bilateral L3 and bilateral L4. Mechanical low back pain r/o facet vs disc.

XXXX: Office Visit with XXXX. Pt c/o BLE cramping in the thigh anteriorly and thigh medially and LLE pain noted in the thigh anteriorly and thigh medially. Current VAS 2-3/10. Symptoms are somewhat better since last visit. Pt states XXXX is better overall but is now having severe leg cramps worse on the left thigh. Muscle spasms are associated with the pain. Response SNRB Lumbar: Bilateral L4 and left L3 spinal nerve transforaminally. Pt had a positive steroid response with 75% relief of symptoms. Relief lasted to date. Currently pt has 75% relief. Post-op was complicated by nausea and vomiting. XX, XX, XX, XX. Light touch sensation decreased in the following dermatomes: left-L3 across the front of the thigh and into the inside part of the knee. L4 into the kneecap area and down to the inside ankle region. L5 down the outside of the thigh/back of the leg, into the leg/shin and into the middle of the foot. Gait antalgic and slow & guarded. Straight leg raise while seated was positive bilaterally for low back pain and radiating leg pain. Tenderness at left lower lumbar paravertebral and left gluteal. ROM is normal in flexion, extension, rotation and lateral bending despite pain with extension and rotation bilaterally, L>R. Recommend Lumbar selective nerve root block/Tranforaminal ESI: Left L3 and L4.

Epidurogram Interpretation: Pt now with similar symptoms from before injection on XXXX. The injection provided pain relief for over 4 months. Now pain is constant. Medications, therapy, and activity modifications are no longer providing substantial pain relief. XXXX has significant spinal pathology of the L3-L4 level with disc degeneration, 4mm disc protrusion, and central spinal stenosis at L3-L4, L4-5, and L5-S1. +SLR on the left hypoesthesia in the L3, L4, L5 dermatomal pattern. Pain worse with extension. Pain also with sitting as well as ambulation. The pain is now interfering with ADL's and QOL.

XXXX: Office Visit WI/EMG Results with XXXX. Etruded and cranially migrated disc herniation on the left L3-4 with associated stenosis lumbar radiculopathy status post work related injury. Awaiting spinal injection. D/C XX, XX. XXXX has had nerve test preformed. XXXX remains on XX, XX and anti-inflammatories for XXXX residual left thigh pain. New Medications: XX 75mg. Problems added in today's visit- displacement of lumbar intervertebral disc without myelopathy. Lumbar radiculopathy. Low back pain. Coordination/balance: antalgic. Posture: forward flexed. Bilateral tenderness to palpation, radiates down bilaterally. Left side pain to straight leg raise. Femoral stretch test: right. Weakness: yes. Lumbar ROM: Flexion: Mid tibias with pain. Extension: neutral with pain better. Rotation: Right: decreased Left: decreased. There is a positive right femoral nerve stretch test. XXXX is unable to single-leg toe raise, right worse than left. There is an asymmetric elevation of the right hemisphere and left shoulder. XXXX is stooped in the sagittal plane with a trunk shift to the right. There is bilateral sciatic notch and hip bursa tenderness on palpation. There is a positive left hip impingement sign. Antalgic gait. Left EHL: 4/5. Bilateral IP: giveway. Sensation is subjectively intact

to light touch to the C5-T1 dermatomes in the bilateral upper extremities with the exception of: left anterior and lateral thigh, left posterior and lateral calf, right medial calf. Deep tendon reflexes in the LE are normal bilaterally. Toes are down going bilaterally. Clonus is absent.

XXXX: Office Visit with XXXX. Current VAS: 5/10. Symptoms are gradually worsening since last visit. Pt also c/o LLE pain is noted in the L3, L4, and L5 distribution. Pain gets worse with sitting. Increased back pan with ambulation, LE claudication and insomnia.

XXXX: UR by XXXX. Rationale- There are no objective findings on exam of a radiculopathy to support a selective nerve root injection. The lumbar MRI showed nerve root compression at L2-3 through l5-S1 but it is not clear from the record if the claimant is symptomatic from any of the compressive lesions. The most recent history on XXXX is vague and insufficiently detailed to determine which, if any root is involved. In speak with NP, XXXX stated the claimant underwent bilateral L4 nerve blocks and left L3 nerve block on 7/11/17 and did well. Now the request is for a left L3-4 transforaminal LESI which would target the left L3 root. But previously according to NP, the claimant responded to injections of the left L3 and the left L4 root. But it is not known if the response was because both were symptomatic or if it was only L3 or only L4 that was symptomatic. Now it is proposed that only the left L3 root be injected but it is not clear that is the symptomatic root. Non-certified.

XXXX: UR by XXXX. Rationale- Previous denial noted limited objective findings for an ongoing lumbar radiculopathy stemming from the left L3 or L4 nerve roots. The provided records would not support overturning the previous decision. Records did not include any recent imaging of the lumbar spine noting evidence of the nerve root compression or the impingement that would correlate with the reported physical exam findings. There was also no documentation regarding recent conservative options such as physical therapy. NP via phone call noted that the pt's MRI correlates with XXXX symptoms. XXXX mentioned that XXXX will fax the result to us. No additional records have been received. Non-certified.

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

The previous adverse decisions are Upheld based on the records provided and peer reviewed guidelines. There are limited objective findings for an ongoing lumbar radiculopathy stemming from the left L3 or L4 nerve roots. Records did not include any recent imaging of the lumbar spine noting evidence of the nerve root compression or the impingement that would correlate with the reported physical exam findings. There was also no documentation regarding recent conservative options such as physical therapy. Therefore, the request for Selective Nerve Block at Left L3-4 is considered not medically necessary.

PER ODG…..

XX

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)**