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Notice of Independent Review Decision

March 9, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar nerve block at L3

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

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.

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 patient is a female who was at work on xx/xx/xx, with another employee. The other employee was about to fall, but the patient helped him from falling. After helping the employee, the patient tried to stand up straight and noticed immediate pain across the lower back, mainly on left.

2014: On xx/xx/xx, evaluated the patient for complaints of left low back pain with changes in position. There was pain with walking, sitting and standing straight. Examination of the back revealed mild/moderate tenderness to palpation over the lumbar spine at L2-L4, moderate tenderness to palpation in the left paralumbar musculature from L1-L4 and mild tenderness to palpation in the right paralumbar musculature at L2-L4. The left paralumbar musculature was tight to palpation. There was moderate pain with changing position. diagnosed lumbar strain, administered Toradol injection, prescribed Norco, ibuprofen and Flexeril and

ordered x-rays of the lumbar spine. The patient was to follow up with occupational medicine.

X-rays of the lumbar spine revealed mild scattered disc degeneration throughout the lumbar spine, vascular calcifications and surgical clips overlying the right upper abdomen.

On September 18, 2014, evaluated the patient for 7-10 lumbar pain. Examination revealed pain with palpation of the paraspinous muscles at L4-S1 on the left. prescribed Anaprox and recommended heat/US x3. The patient was to return to work with modifications.

On September 19, 2014, and September 22, 2014, applied heat and ultrasound (US) to the lumbar spine.

On September 25, 2014, the patient complained of 4/10 pain. She had switched to over-the-counter (OTC) nonsteroidal antiinflammatory drugs (NSAIDs) due to gastric upset with treatment. Ms. Compton recommended continuing OTC NSAIDs and initiating physical therapy (PT) three times a week for two weeks with home exercises.

From September 30, 2014, through October 17, 2014, the patient underwent six visits of PT with modalities to include moist heat, stretching exercises and therapeutic exercises.

On October 20, 2014, noted the lumbar pain was wrapping around the left hip and to the groin area. The patient rated the pain at 8/10. It was worsened by anything. The patient reported little improvement over the course of PT. Examination revealed tenderness on palpation in the lower back, tenderness to palpation at L5-S1 on the left, pain without radiculopathy with straight leg raising (SLR) and mild scoliosis to the thoracic spine. Left hip revealed limitations in range of motion (ROM). The patient was recommended x-ray of the pelvis and left hip and magnetic resonance imaging (MRI) of the lumbar spine. PT was discontinued.

On October 20, 2014, x-rays of the pelvis with lateral views of the left hip revealed mild degenerative changes of the lower lumbar spine, otherwise unremarkable.

On October 30, 2014, an MRI of the lumbar spine revealed lesion in the upper pole of the right kidney possibly representing a simple cyst; however, a follow-up renal sonogram was recommended to confirm. There were multilevel degenerative disc and facet disease most notably at L4-L5.

On November 4, 2014, noted 7/10 pain in the low back. The patient had difficulty with prolonged positioning and sleep. Findings of the MRI were reviewed. The patient was referred to neurosurgery and primary care physician (PCP) for incidental findings on MRI. Tramadol was refilled and smoking cessation was encouraged.

On November 14, 2014, evaluated the patient for ongoing low back pain. The patient reported less relief of pain from medications. Pain medications allowed four hours of sleep. It was noted the patient had eight PT sessions. The patient was at 44% disability on the Oswestry Disability Index. The patient had tightness in the lower back. Examination revealed positive SLR test on left at 45 degrees, 4/5 quadriceps weakness, weakness in the tibialis anterior and extensor hallucis longus (EHL) on the left at 4/5, moderate point tenderness over the facet area at L4-L5, slight sensory deficit to anterior aspect of left thigh and 1+ reflexes at L4 and S1 on the left. diagnosed left L4 and L5 radiculopathy secondary to lateral herniated discs at L3-L4 and L4-L5. The patient was thought to be a great candidate for epidural steroid injection (ESI) at L3-L4 level on the left.

On December 2, 2014, the patient underwent an ESI at left L3-L4.

On December 18, 2014, the patient reported the ESI took the edge off, but pain was still moderate. It gave her about 40% relief for five days before it took the edge off. The patient was at 52% disability on the Oswestry Disability Index. Examination revealed a positive SLR at 60 degrees. refilled Tylenol and referred the patient to have a look at her MRI.

2015: Per utilization review dated January 15, 2015, the request for L3 nerve block (64483) injection foramen epidural lumbar spine injection, anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or CT) lumbar or sacral single level was denied with the following rationale: *"I have reviewed the information provided on xx/xx/xx, DOI. Low back. Records document December 2, 2014, lumbar left L3-L4 ESI. December 18, 2014, note documents patient self-report of little relief. Pain is reported to be moderate with about 40% relief. Request for ESI is not medically reasonable in absence of adequate response to initial ESI."*

Per a reconsideration review dated February 3, 2015, the appeal for denial of L3 nerve block (64483) injection foramen epidural lumbar spine injection, anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or CT) lumbar or sacral single level was denied with the following rationale: *"I discussed this case who stated he is authorized to do the peer call on behalf of the requesting physician. He reports the previous injection was a translaminar epidural steroid injection at L3-L4. He states the request for L3 nerve block is to isolate which level may be causing the problem. This is a non-certification of a request for reconsideration of a lumbar nerve block at L3. The previous non-certification was due to lack of adequate response to the initial epidural steroid injection. The previous non-certification is supported. Additional records were not submitted. Lumbar epidural steroid injections would be supported for radiculopathy which is documented on physical examination and corroborated on imaging studies and/or electrodiagnostic testing. The most recent physical examination documented intact sensation and symmetric deep tendon reflexes. There was no frank nerve root compromise on MRI. There should be unresponsiveness to lower levels of care. There was no notation of failure of a*

muscle relaxant and the patient had only attended eight sessions of physical therapy. Failure of a home exercise program was not noted. There should be 50-70% pain relief from previous injections lasing six to eight weeks. The patient only received 40% relief for five days. The request for reconsideration of a lumbar nerve block at L3 is not certified. Determination: The request is not certified."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Epidural steroid injections can be delivered using interlaminar, transforaminal, or caudal approaches, depending on the location and the source of the pain. The evidence for cervical and lumbar transforaminal ESIs is moderate for long-term improvement in managing nerve root pain
According to the ODG, a maximum of two injections should be administered in the diagnostic phase, which helps to confirm the suspected pain generator and to determine whether the injections provide pain relief.[ODG, 2008] A second injection is not recommended if there is an inadequate response to the first injection, unless the source of pain is in question, there was possibility of inaccurate placement, or there is evidence of multilevel pathology. There should be an interval of at least one to two weeks between injections.

In this case, an interlaminar epidural steroid injection, left paramedian L34 approach, was performed with an inadequate response. However, the patient was diagnosed with a left L4 and L5 radiculopathy secondary to lateral herniated lumber disc at L34 and L45 per the note dated, 11/14/2014. According to the Lumber MRI, the greater pathology appears to be at the L45 level. In my opinion, there is a question of the source of pain and there is evidence of multilevel pathology. Per the ODG, a second diagnostic LESI is indicated, but not at the left L3 level. Thus, the request for a left L3 nerve block is not certified.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES