

<b>Case Number:</b>	CM14-0110223		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	06/06/2007
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Pain Management and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 61-year-old female with date of injury of 08/08/2007. The listed diagnoses per [REDACTED] are: 1. Transitional syndrome, C3-C4, with protrusion with bilateral neuroforaminal stenosis left more than right. 2. Left C4 radiculopathy with deltoid symptomatology. 3. Status post transforaminal lumbar interbody fusion, 08/31/2011. 4. Cervical and lumbar myofascial pain syndrome with residuals. 5. Gastric intolerance of antiinflammatory medications. 6. Rule out high-grade spinal stenosis at T12-L1 level versus other recurrent or residual protrusions. According to progress report 05/13/2014, the patient presents with constant neck and low back pain. Low back pain is rated at 7/10 with radiation to the left lower extremity, down the buttock, and into the right leg and toes. There is tingling sensation to the right foot noted. MRI of the lumbar spine from 05/02/2014 revealed at level L1-L2, "There is no disk desiccation. There is a mild loss of posterior intervertebral disk height. There is a 2-mm central posterior disk protrusion with bilateral paracentral extension indenting the thecal sac." Examination revealed weakness in the bilateral iliopsoas muscle groups at 3+/5, more on the right rather than the left. Pain is radiating to the level of the bilateral knees but not below the knees. Extensor hallucis longus in foot eversion, motor groups are symmetrically bilateral. Treater is requesting a selective nerve root block at the bilateral L1 level. Utilization review denied the request on 06/13/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Bilateral L1 selective nerve root block under sedation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three."Criteria for the use of Epidural steroid injections:Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.1) Radiculopathy must be documented by physical examination and 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) for guidance.4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at 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) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We r

**Decision rationale:** This patient presents with low back pain that radiates to the bilateral lower extremities up to the knee. The provider is requesting a bilateral L1 selective nerve root block under sedation. MTUS recommends ESIs for clear diagnosis of radiculopathy that required dermatomal distribution of pain/paresthesia, confirmed via examination findings as well as imaging studies. In this case, the patient presents with back pain with radiation down to the bilateral lower extremities; however, the MRI from 05/02/2014 does not corroborate patient's pain. The MRI revealed at level L1-L2, mild loss of posterior intervertebral disk height with 2-

mm central posterior disk protrusion, the significance of which is doubtful for any nerve root irritation or pathology. Furthermore, the patient does not present with L2 radicular symptoms and the provider does not describe the location of leg symptoms that may corroborate an L2 level problem. The request for Bilateral L1 selective nerve root block under sedation is not medically necessary.