MAXIMUS Federal Services

| Case Number: | CM15-0063250 | | |
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| Date Assigned: | 04/09/2015 | Date of Injury: | 03/15/2013 |
| Decision Date: | 05/15/2015 | UR Denial Date: | 03/12/2015 |
| Priority: | Standard | Application Received: | 04/02/2015 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, District of Columbia, Maryland
Certification(s)/Specialty: Anesthesiology, Pain Management

## 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 injured worker is a 52 year old female, who sustained an industrial injury on 3/15/2013. Diagnoses include sprain and strain of sacroiliac and displacement lumbar disc without myelopathy. Treatment to date has included diagnostics, chiropractic care, medications, and physical therapy. Per the Primary Treating Physician's Progress Report dated 2/16/2015, the injured worker reported constant lower back pain that is described as unimproved since her last evaluation. Left leg pain remains intermittent. Physical examination revealed normal/active DTRs, intact motor strength in the lower extremities and a positive Dejerine's test for increasing back pain with radiation into the left buttock/posterior thigh. The plan of care included modified work and authorization was requested for left S1 selective nerve root block.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Left S1 selective nerve root block:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for the use of Epidural steroid injections and on the Non-MTUS ASIPP Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Epidural Steroid Injections, diagnostic.

**Decision rationale:** Recommended in selected cases as indicated below. Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed, in part, as a diagnostic technique to determine the level of radicular pain. The role of these blocks has narrowed with the advent of MRIs. Few studies are available to evaluate diagnostic accuracy or post-surgery outcome based on the procedure and there is no gold standard for diagnosis. No more than 2 levels of blocks should be performed on one day. The response to the local anesthetic is considered an important finding in determining nerve root pathology. (CMS, 2004) (Benzon, 2005) When used as a diagnostic technique a small volume of local is used (<1.0 ml) as greater volumes of injectate may spread to adjacent levels. (Sasso, 2005) (Datta, 2013) (Beynon, 2013)Indications for diagnostic epidural steroid injections: 1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below: 2) To help to evaluate a radicular pain generator when physical signs and symptoms differ from that found on imaging studies; 3) To help to determine pain generators when there is evidence of multi-level nerve root compression; 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive; 5) To help to identify the origin of pain in patients who have had previous spinal surgery. Per the documentation submitted for review, MRI of the lumbar spine dated 9/9/14 revealed loss of disc height and a 6mm central/left-paracentral disc herniation at L5-S1 which places pressure on the descending left S1 nerve root. Per the above cited indications, SNRB is recommended when diagnostic imaging is ambiguous. As the criteria is not met, the request is not medically necessary.