

Case Number:	CM15-0134212		
Date Assigned:	07/24/2015	Date of Injury:	10/08/2014
Decision Date:	08/20/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/10/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 44 year old male, who sustained an industrial injury on 10/8/14. The injured worker has complaints of low back pain with intermittent left lower extremity numbness and tingling and occasional weakness. The documentation noted that the injured worker had reported that his pain was around 2 to 3 out of 10 and annoying but manageable, then on 3/26/15 the injured worker was stopped at a red light and stepped in gravel causing the bike to fall toward the left and that he reported that he caught the 600 pound bike and felt another pop in his low back and numbness and tingling into the left lower extremity. The documentation noted the injured worker on 4/20/15 took a long ride and once his pain was unbearable he had to stop riding and had to ride back in a truck with ice. The documentation noted palpation and paraspinal spasm and straight leg raise is positive on the left at 50 degrees. The diagnoses have included lumbar spine herniated nucleus pulposus L5-S1 (sacroiliac) 0.5cm with radiculopathy. Treatment to date has included bilateral L5 nerve block with sedations; anti-inflammatory medications; stretching and magnetic resonance imaging (MRI) of the lumbar spine on 4/29/15 showed T12-L1, there is no disc abnormality, central canal stenosis or neuroforaminal narrowing. The request was for bilateral L5 nerve block with sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L5 Nerve Block with Sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Pain Procedure Summary, Online Version, Sedation for ESI.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) epidural injections and pg 47.

Decision rationale: According to the guidelines, Criteria for the use of diagnostic blocks for facet 'mediated' pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a 'sedative' during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) In this case, there is mention of radiculopathy of L5. This would not meet the guidelines criteria above. The request for the lumbar block is not medically necessary.