

Case Number:	CM15-0143227		
Date Assigned:	08/04/2015	Date of Injury:	12/10/2013
Decision Date:	09/02/2015	UR Denial Date:	07/13/2015
Priority:	Standard	Application Received:	07/23/2015

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 54 year old male who sustained an industrial injury on 12-1-13. In an orthopaedic re-evaluation dated 6-2-15, the treating physician notes he is now three and a half months status post extraforaminal discectomy at L3-4 and L4-5 on the left and the injured worker reports he is doing worse and he has ongoing leg pain with associated numbness and weakness. Lumbar motion is severely limited due to pain. A motor exam of the lower extremities, reveals 5 out of 5 on the right and 3 out of 5 on the left. He has stopped physical therapy because of the pain and requires narcotic medication. Multiple attempts have been made to wean off the medication, without success. In an orthopaedic re-evaluation dated 6-30-15, the treating physician notes exam of the lumbar spine notes a limited range of motion. sensory exam on the left is decreased in the anterior thigh. An MRI reveals evidence for the extraforaminal discectomy at L3-4 and L4-5, evidence for epidural fibrosis at both levels, L4-5 moderate central canal stenosis and L3-4 mild central canal stenosis. The requested treatment is selective nerve root block L3-4 and L4-5 and pre-operative medical clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Selective nerve root block L3-4 and L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter and pg 36.

Decision rationale: According to the guidelines, selective nerve root blocks fall under similar guidelines as medical branch blocks. 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) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. In this case, the claimant does have radicular findings on exam and prior diagnostics. Invasive procedures are not recommended by the ACOEM guidelines due to their short term benefit. As a result, the request for the facet block is not medically necessary.

Pre-op medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: According to the guidelines, selective nerve root blocks fall under similar guidelines as medical branch blocks. 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) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. In this case, the claimant does have radicular findings on exam and prior diagnostics. Invasive procedures are not recommended by the ACOEM guidelines due to their short term benefit. As a result, the request for the facet block is not medically necessary. As noted above, since the procedure is not recommended, the pre-op clearance is not medically necessary.