

Case Number:	CM14-0143932		
Date Assigned:	09/12/2014	Date of Injury:	04/14/2004
Decision Date:	10/07/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/05/2014

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 Physical Medicine & 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 54 years old female with an injury date on 04/14/2004. Based on the 08/01/2014 progress report provided by [REDACTED], the diagnoses are status post lumbar fusion L4-5 and L5-S, adjacent segment disease, failed back syndrome and lumbar radiculopathy. According to this report, the patient complains of mid back pain at 9/10 and low back pain at 9/10 with radiating pain to the bilateral lower extremities down to the calves. The "back pain is much more severe than her leg complains." The patient is unable to ambulate due to her complains and is using a wheelchair. Physical exam reveals tender to palpation about the thoracic and lumbar spine. Motor strength of the lower extremities is decreased. There were no other significant findings noted on this report. The utilization review denied the request on 08/28/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 07/29/2014 to 08/01/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial Branch Block at Bilateral L2-3 and L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Facet injection, RF ablation, cervical and lumbar.

Decision rationale: According to the 08/01/2014 report by [REDACTED] this patient presents with mid back pain at 9/10 and low back pain at 9/10 with radiating pain to the bilateral lower extremities down to the calves. The treater is requesting medial branch block at bilateral L2-3 and L3-4. Regarding medial branch blocks, MTUS does not address it, but ODG low back chapter recommends it for "low-back pain that is non-radicular and at no more than two levels bilaterally." Review of the reports do not show any evidence of prior MMB being done in the past. The patient has radiating low back pain that travel to the bilateral lower extremities. In addition, physical exam does not indicate the patient has paravertebral facet tenderness. Therefore, the requested MBB is not in accordance with the ODG Guidelines at this time. Recommendation is for denial.

Motorized Scooter: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Powered Wheel Chairs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99.

Decision rationale: According to the 08/01/2014 report by [REDACTED] this patient presents with mid back pain at 9/10 and low back pain at 9/10 with radiating pain to the bilateral lower extremities down to the calves. The treater is requesting a motorized scooter. Regarding Power Mobility Devices, MTUS guidelines state "Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair." Review of reports show no functional mobility deficit and the patient is using a wheelchair to move about. MTUS further state "if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." Recommendation is for denial.