

<b>Case Number:</b>	CM13-0045502		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	07/20/1999
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	10/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2013

### 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 and Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 who reported an injury on 07/20/1999. The mechanism of injury was not provided for review. The patient was evaluated on 09/24/2013. It was documented that the patient had cervical and lumbar spine pain that radiated into the bilateral upper and lower extremities, rated at a 7/10. Physical findings included tenderness to palpation with decreased range of motion of the cervical spine and decreased sensation in the C6-8 dermatomes with positive facet loading. The evaluation of the low back documented tenderness to palpation in the paraspinal musculature with severely decreased range of motion secondary to pain and positive facet loading in the L3-4 and L4-5 regions. It was also documented that the patient had decreased sensation in the L4-S1 dermatomal distributions with a positive left-sided straight leg raising test, and a 5-/5 motor strength of the bilateral lower extremities. It was documented that the patient's axial back pain was her primary pain generator, and a medial branch block was requested to assess the patient's appropriate for a radiofrequency ablation. Additionally, a motorized scooter was requested to assist with ambulation. The patient's diagnoses included cervical radiculopathy, lumbar radiculopathy, cervical facet arthropathy, and lumbar facet arthropathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MEDIAL BRANCH BLOCKS AT L3-4 AND L4-5:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) MEDIAL BRANCH BLOCKS

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER, FACET JOINT PAIN, SIGNS & SYMPTOMS AND FACET JOINT INJECTIONS (DIAGNOSTIC).

**Decision rationale:** The requested medial branch blocks at the L3-4 and L4-5 are not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address medial branch blocks. The Official Disability Guidelines recommend medial branch blocks for facet-mediated pain that is recalcitrant to physical therapy, in preparation for a radiofrequency ablation, and in the absence of a radiculopathy. However, Official Disability Guidelines also note that if radiculopathy is present, if there is evidence of hypertrophy encroaching on the neural foramen, medial branch blocks would be appropriate to determine the patient's pain generator. The clinical documentation submitted for review does provide evidence of both radiculopathy and facet mediated pain. Therefore, an imaging study providing evidence of hypertrophy and neural foramen encroachment would be needed. The clinical documentation does indicate that the patient has undergone an MRI of the lumbar spine. However, an independent review of that MRI was not provided for review. As such, the requested medial branch blocks at the L3-4 and L4-5 are not medically necessary or appropriate.

**THE PURCHASE OF A MOTORIZED SCOOTER:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines POWER MOBILITY DEVICES Page(s): 99.

**Decision rationale:** The requested purchase of a motorized scooter is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of a motorized scooter for patients who have ambulation deficits that cannot be sufficiently resolved with lower levels of equipment. The clinical documentation submitted for review does indicate that the patient is having increasing difficulty with ambulation, with the assistive device of a quad cane. However, the documentation fails to address why the patient's deficits cannot be sufficiently resolved with an optimally-configured manual wheelchair. Therefore, the need for a motorized scooter is non-certified. As such, the requested motorized scooter is not medically necessary or appropriate.