

<b>Case Number:</b>	CM13-0009127		
<b>Date Assigned:</b>	09/13/2013	<b>Date of Injury:</b>	02/24/2010
<b>Decision Date:</b>	01/15/2014	<b>UR Denial Date:</b>	07/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/08/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in New York and Texas. 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 physician 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 36-year-old female who reported a work-related injury on 02/24/2010 as a result of a fall. Clinical note dated 06/21/2013 reports the patient was seen under the care of [REDACTED]. The provider documents the patient presents with complaints of lumbar spine and left shoulder pain. The provider documents the patient's course of treatment since the date of injury. The provider documents the patient complains of constant, severe pain that was described as sharp and radiating down the right lower extremity. The provider documented the patient presented with decreased range of motion of the lumbar spine with 35 degrees of flexion, 10 degrees of extension, 11 degrees of left bending, 15 degrees of right bending, and 10 degrees of bilateral rotation. The provider documented sensation was decreased at the L5 dermatome on the right to light touch and the S1 dermatome was decreased on the right to light touch. The provider documented there was no diagnostic imaging or testing submitted for his review. However, the provider indicated the patient required surgical consultation for the lumbar spine and the right shoulder to examine to rule out need for surgery. In addition, the provider recommended a multi-inferential stimulator and a lumbosacral orthotic was prescribed for the patient in order to stabilize the lumbar spine and promote healing.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T9 vertebra, produces intracavitary pressure to reduce load on TH: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 248.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:**