

Case Number:	CM13-0050057		
Date Assigned:	12/27/2013	Date of Injury:	03/17/1999
Decision Date:	03/06/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/08/2013

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 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 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 61-year-old male who reported an injury on 3/17/99. The mechanism of injury was not provided. The patient had an MRI of the cervical spine on 7/29/13 which revealed mild right C3 neural foraminal stenosis due to uncovertebral joint hypertrophy. There was noted to be no spondylolisthesis and alignment was noted to be normal. The patient was noted to have no abnormal translation on flexion and extension views of the x-rays of the cervical spine on the same date. The patient was noted have a high level of constant pain in the neck, partially controlled with a collar. The patient was noted to be dependent on the collar, wearing it nearly daily all of the time he is upright. The patient was noted to sleep on a massage table face down. The patient's medications were noted to be methadone, Flexeril, Oxycodone, Lunesta, Celebrex, Lisinopril, and Xanax. The patient's cervical range of motion was noted to be limited to about 20% of normal. There was noted to be a trace of ulnar hypoesthesia on the right, and neural tension testing increased the tingling of the patient's arm greater on the right than on the left. The patient's diagnoses include multi trauma, degenerative cervical, thoracic, and lumbar spine disease with disc, facet, and ligamentous degeneration post lumbar fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Body buoy bracing system flexible scapulo-spinal orthosis with accessories: Upheld

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

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

Decision rationale: ACOEM guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, continued use of back braces could lead to deconditioning of the spinal muscles. The clinical documentation submitted for review indicated that the patient had bilateral parascapular weakness, and thoracic outlet syndrome. The body buoy is a padded, rigid scapulothoracic orthosis that fits any chair or vehicle; it was the most practical solution adopted in the office of the physician. The scapulothoracic orthosis evolved over the last 10 years and was proprietary to the physician's office. There was a lack of documentation of myotomal findings and, as such, there was a lack of documentation indicating the patient had instability that would necessitate bracing. Given the above, the request is not medically necessary.