

Case Number:	CM14-0005517		
Date Assigned:	02/05/2014	Date of Injury:	01/10/2011
Decision Date:	07/11/2014	UR Denial Date:	01/09/2014
Priority:	Standard	Application Received:	01/15/2014

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 Occupational Medicine, 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 40-year-old female who has submitted a claim for rule out cervical disc injury, right shoulder pain, elbow pain, lumbar spondylosis, chest wall pain, status post left arthroscopic subacromial decompression associated with an industrial injury date of January 10, 2011. Medical records from 2013 were reviewed. The patient complained of low back pain, grade 7/10 in severity. The pain radiates to the lower extremity, left greater than the right. Physical examination showed tenderness of the lumbar area. There was limited range of motion of the lumbar spine. Straight leg raise test was positive on the right. Motor testing was 4/5 on the left quadriceps, left tibialis anterior, left extensor hallucis longus, and on left eversion. Sensation was intact. MRI of the lumbar spine, dated March 8, 2013, revealed mild, chronic right L5-S1 facet hypertrophy. Treatment to date has included medications, physical therapy, chiropractic therapy, home exercise program, myofascial release, interferential current, activity modification, and shoulder surgery. Utilization review, dated January 9, 2014, denied the request for retro LSO brace date dispensed 11/25/13 qty:1.00 because objective examination findings to indicate the need for the request were not established.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR-SACRAL ORTHOSIS (LSO) BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar supports.

Decision rationale: According to page 301 of the ACOEM Practice Guidelines referenced by CA MTUS, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG low back chapter states that back braces are indicated for management of compression fractures, spondylolisthesis, and instability. In this case, a lumbar spine orthosis was requested to provide stability and facilitate improved tolerance to standing and walking. However, there was no objective evidence of lumbar fracture or instability from the medical records submitted. In addition, patient has persistent back pain which is beyond the acute phase. There was no documentation of whether the patient has suffered an acute exacerbation of the back pain. The medical necessity has not been established. Therefore, the request for LUMBAR-SACRAL ORTHOSIS (LSO) BRACE is not medically necessary.