MAXIMUS Federal Services

Case Number:	CM14-0103388		
Date Assigned:	09/16/2014	Date of Injury:	02/17/2014
Decision Date:	10/15/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	07/03/2014

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 Therapy and Rehabilitation, has a subspecialty in Pain Management 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:

This is a male patient with the date of injury of February 17, 2014. A Utilization Review was performed on June 11, 2014 and recommended non-certification of DME: lumbar support orthosis specifically [redacted] LSO or equivalent and Physical Medicine: follow up visit with range of motion measurement and addressing ADLs 3x2. An Initial Evaluation dated May 28, 2014 identifies Present Complaints of frequent moderate pain that was described as dull and sharp. The pain and burning sensation radiated downward into the bottom of his feet. Examination identifies +3 spasm and tenderness to the bilateral lumbar paraspinal muscles from L1 to S1 and multifidus. Decreased lumbar spine range of motion. Kemp's test was positive bilaterally. Yeoman's test was positive bilaterally. Diagnostic Impression identifies lumbar disc displacement without myelopathy. Treatment Plan identifies the patient requires a program of physical medicine for 6 visits with continuation dependent on functional improvement and a lumbosacral orthosis (LSO). There is note of treatment goals.

IMR ISSUES, DECISIONS AND RATIONALES

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

lumbar support orthosis, specifically [redacted] LSO or equivalent: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines low back. Decision based on Non-MTUS Citation Official Disability Guidelines, low back

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: Regarding the request for lumbar support orthosis, specifically [redacted] LSO or equivalent, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state the lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. ODG goes on to state that for nonspecific low back pain, compared to no lumbar support, elastic lumbar belt maybe more effective than no belt at improving pain at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However, the evidence was very weak. Within the documentation available for review, it does not appear that this patient is in the acute or subacute phase of his treatment. Additionally, there is no documentation indicating that the patient has a diagnosis of compression fracture, spondylolisthesis, or instability. As such, the currently requested lumbar support orthosis, specifically [redacted] LSO or equivalent is not medically necessary.

Physical medicine: follow up visit with range of motion measurement and addressing ADLs three times per week for two weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines low back. Decision based on Non-MTUS Citation Official Disability Guidelines, low back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298,Chronic Pain Treatment Guidelines Page(s): 98 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy

Decision rationale: Regarding the request for physical medicine: follow up visit with range of motion measurement and addressing ADLs three times per week for two weeks, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. In the absence of such documentation, the current request for physical medicine: follow up visit with range of motion measurement and addressing ADLs three times per week for two weeks is not medically necessary.