

Case Number:	CM14-0111862		
Date Assigned:	08/01/2014	Date of Injury:	04/06/2010
Decision Date:	09/09/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	07/17/2014

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 Pain Management, has a subspecialty in Rehabilitation and is licensed to practice in 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 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 injured worker is a 56 year old female injured on 04/06/10 as a result of a fall. Diagnoses include cervical discopathy with right upper extremity radiculopathy and assisted cervicogenic headaches, lumbar spine mild ligamentous injury with right lower extremity radicular symptoms, medication induced gastritis, and right shoulder internal derangement status post subacromial decompression on 04/21/11. Clinical note dated 06/02/14 indicates the injured worker presented complaining of chronic neck pain radiating to the right shoulder and right upper extremity aggravated by bending, twisting, and turning. The injured worker rated her pain at 7/10. The injured worker also complained of lower back pain radiating to the right lower extremity, L5 to S1 distribution. Documentation indicated electrodiagnostic studies of the right upper extremity revealed right carpal tunnel syndrome. Physical examination revealed decreased cervical and lumbar range of motion, motor strength 5/5, deep tendon reflexes 1+ triceps and brachioradialis on the right, tenderness to palpation to the lumbar paravertebral musculature and sciatic notch region, trigger points and taut bands with tenderness to palpation noted throughout, and positive straight leg testing bilaterally. The initial request for lumbosacral orthotics support brace was initially noncertified on 06/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbosacral Orthotic Support Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back Complaints, Clinical Measures, Devices, Lumbar Supports.

Decision rationale: As noted in the California Medical Treatment Utilization Schedule (MTUS), lumbar support (corset) is not recommended for the treatment of low back disorders. Postoperative utilization is under study. As such, the request for lumbosacral orthotic support brace is not medically necessary at this time.