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| Case Number: | CM14-0129768 | | |
| Date Assigned: | 08/20/2014 | Date of Injury: | 06/03/2011 |
| Decision Date: | 10/01/2014 | UR Denial Date: | 08/11/2014 |
| Priority: | Standard | Application Received: | 08/14/2014 |

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 Anesthesiology, has a subspecialty in Pain Medicine 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 59 year old male who reported an injury to his low back as a result of a work related injury on 06/03/11. The utilization review dated 08/11/14 resulted in a non-certification for a sacral orthosis with a light back support and rigid back as no information had been submitted confirming the injured worker's compression fracture or spondylolisthesis or any documented instability. The clinical note dated 06/24/14 indicates the injured worker utilizing Ibuprofen and Vicodin for pain relief. The clinical note dated 02/21/14 indicates the injured worker demonstrating range of motion deficits throughout the lumbar region to include 47 degrees of flexion, 20 degrees of extension, 20 degrees of bilateral lateral flexion, and 20 degrees of bilateral rotation.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 LUMBAR SACRAL ORTHOSIS LIGHT BACK SUPPORT WITH RIGID BACK:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Support

Decision rationale: The documentation indicates the injured worker complaining of ongoing low back pain. A back support is indicated for injured workers who have documentation of spondylolisthesis, instability, or as part of a postoperative recovery. No information was submitted regarding the injured worker's significant clinical findings indicating the likely benefit of a lumbar support. Additionally, no information was submitted regarding the injured worker's previous completion of any operative procedures. Therefore, this request is not indicated as medically necessary.