

Case Number:	CM14-0163745		
Date Assigned:	10/08/2014	Date of Injury:	02/19/2003
Decision Date:	12/10/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/06/2014

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 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 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 69-year-old male who reported an injury of unspecified mechanism on 02/19/2003. On 09/08/2014, his diagnoses included rotator cuff syndrome of the right shoulder, impingement syndrome of the right shoulder, and herniated disc of the lumbar spine. His complaints included lumbar spine pain radiating to both lower extremities and right shoulder pain radiating to both upper extremities. This pain is increased with activity, pushing, pulling, and reaching. He had numbness and tingling in both hands. He had a bilateral positive straight leg raising test. There were spasms and tenderness palpable in the lumbar spine. There was also tenderness to palpation of the right shoulder. His treatment plan included continuing with medications, including Vicodin extra strength, Lidoderm patches, diclofenac, Xanax, and Colace, of unspecified dosages, physical therapy for exacerbation of pain with limited range of motion and spasms for the lumbar spine, and a lumbar brace to support his lumbar spine condition. There was no Request for Authorization included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 Times a Week for 8 Weeks for the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for Physical Therapy 2 Times a Week for 8 Weeks for the Lumbar Spine is not medically necessary. The California MTUS Guidelines recommend active therapy as indicated for restoring flexibility, strength, endurance, function, range of motion, and to alleviate discomfort. Patients are expected to continue active therapies at home. The Physical Medicine Guidelines allow for a fading of treatment frequency from up to 3 visits per week to 1 or less. The recommended schedule for neuralgia, neuritis, and radiculitis unspecified is 8 to 10 visits over 4 weeks. The requested 16 visits of physical therapy exceed the recommendations in the guidelines. Therefore, this request for Physical Therapy 2 Times a Week for 8 Weeks for the Lumbar Spine is not medically necessary.

Lumbar Brace: Upheld

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

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

Decision rationale: The request for Lumbar Brace is not medically necessary. The California ACOEM Guidelines do not recommend lumbar supports for acute lumbar spine disorders. Lumbar support is not recommended for the treatment of low back disorders. Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, the request did not specify whether the requested lumbosacral brace was to be custom made or prefabricated, or the size of the brace. Additionally, it did not specify a frequency of use. Therefore, this request for Lumbar Brace is not medically necessary.