

<b>Case Number:</b>	CM14-0175460		
<b>Date Assigned:</b>	10/28/2014	<b>Date of Injury:</b>	10/09/2000
<b>Decision Date:</b>	12/05/2014	<b>UR Denial Date:</b>	09/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2014

### 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 54-year-old male who reported an injury on 10/09/2000 due to an unspecified cause of injury. The injured worker complained of lower back and lower extremity pain. The injured worker rates his pain as 7/10 to 8/10 using the VAS. The diagnoses included lumbar stenosis with neurogenic claudication and lumbar disc displacement. The diagnostics included an MRI of the lumbar spine performed on 12/17/2013 that revealed moderate to severe bilateral stenosis at the L4-5. At the L3-4, there was moderate spinal stenosis centrally and foraminally due to the disc herniation and facet hypertrophy. Treatment plan included an IFC unit, acupuncture, and medication. Objective findings dated 10/20/2014 of the lumbar spine revealed the injured worker had moderate to severe tenderness on palpation in the mid lumbar spine. Treatment plan included a lumbar support. The Request for Authorization dated 10/28/2014 was submitted with documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Lumbar spine support, QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back - Lumbar and Thoracic (Acute and Chronic), Walking Aids ( Canes, Crutches, Braces, Orthoses and Walkers)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 301.

**Decision rationale:** The request for lumbar spine support, quantity 1, is not medically necessary. The California MTUS/ACOEM indicates that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As such, the request is not medically necessary.