

<b>Case Number:</b>	CM14-0179508		
<b>Date Assigned:</b>	11/04/2014	<b>Date of Injury:</b>	07/03/2013
<b>Decision Date:</b>	12/10/2014	<b>UR Denial Date:</b>	09/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2014

### 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 Orthopedic Spine Surgery 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 52-year-old female who reported an injury on 07/03/2013. The mechanism of injury was not submitted for clinical review. The diagnoses included closed fracture of L1 vertebral body, cervical disc herniation, myelopathy, lumbar disc displacement with myelopathy, lesion of sciatic nerve, thoracic disc displacement without myelopathy. Previous treatments included 18 sessions of acupuncture therapy following medication, 31 sessions of physical therapy, and 6 sessions of chiropractic therapy. Diagnostic testing included an EMG/NCV. Within the clinical note dated 08/20/2014 it was reported the injured worker complained of occasional moderate pain in her head. The injured worker complained of severe pain in the thoracic spine which she described as throbbing. The injured worker complained of severe pain in the lumbar spine which was described as throbbing. Upon the physical examination the provider noted the injured worker had spasms and tenderness in the cervical spine, thoracic spine, and lumbar spine. Lumbar range of motion was measured by external goniometer digital protractor. There was a positive Faberge's test noted bilaterally. Request was submitted for an Apollo lumbosacral orthosis back brace. However, a rationale was not submitted for clinical review. The request for authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Apollo Lumbo Sacral Orthosis Back Brace for Purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back: Lumbar Supports

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

**Decision rationale:** The request for Apollo Lumbo Sacral Orthosis Back Brace for Purchase is not medically necessary. The California MTUS/ACOEM Guidelines note lumbar supports have not been shown to have any lasting benefit beyond the acute phase of relief. There is lack of documentation warranting the medical necessity for the purchase of a back brace. The date of injury was in 2013 which exceeds the guideline recommendations of acute phase of symptom relief. The request is not medically necessary.