

<b>Case Number:</b>	CM14-0047069		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	01/17/2012
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	04/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/15/2014

### 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 Illinois. 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 47 year old male with a reported injury on 01/17/2012. The mechanism of injury was not provided. The injured worker's diagnoses included left shoulder pain status post left shoulder surgery and lumbar spine sprain/strain with myospasms. The injured worker's previous treatments included physical therapy, chiropractic care, and acupuncture. No pertinent diagnostic testing was provided. The injured worker's surgical history included an ORIF for a right upper extremity fracture and rotator cuff repair on 07/31/2012. The injured worker was evaluated for left shoulder and low back pain on 02/24/2014. Regarding his low back pain, the injured worker described his pain as constant, rated 6/10, increased with bending, decreased when lying down, and associated with radiation from mid to low back with numbness and tingling sensations. The clinician observed and reported a focused thoracolumbar spine examination. There was limited range of motion secondary to pain and measured at 47% of normal lumbar flexion, 76% of normal lumbar extension, 80 % of normal left lateral, and 68 % of normal right lateral. Muscularly the right hip flexion was (-) 9% and left hip extension was (-) 18%. The straight leg raise was positive at 40 degrees on the right and 35 degrees on the left. The patellar and Achilles reflexes were 2+ bilaterally. The treatment plan was to request chiropractic therapy, continue acupuncture, request and MR arthrogram of the left shoulder and MRI of the lumbar spine, and request a lumbar spine support. No documentation of any medications was provided. The request was for LSO back support 'since he has not received that yet'. The request for authorization form was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LSO back support:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** The request for LSO back support is not medically necessary. The injured worker complained of low back pain. The California MTUS/ACOEM Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The injured worker's date of injury is 01/17/2012; therefore, the injured worker is no longer in the acute phase of symptom relief. No documentation of lumbar instability or recent lumbar surgery to indicate the use of a brace was provided. Therefore, the request for LSO back support is not medically necessary.