

Case Number:	CM15-0139014		
Date Assigned:	07/29/2015	Date of Injury:	03/18/2014
Decision Date:	08/26/2015	UR Denial Date:	07/16/2015
Priority:	Standard	Application Received:	07/17/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Emergency Medicine

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 49 year old male who sustained an industrial injury on 03/18/2014 when a chair collapsed and he fell to the floor. The injured worker was diagnosed with unstable spine (sacrum), cervicobrachial syndrome, trochanteric bursitis and rotator cuff sprain/strain. Treatment to date has included diagnostic testing, physical therapy (6 visits), functional capacity evaluation (FCE), psychological evaluation, trial functional restoration program (FRP), home exercise program and medications. According to the primary treating physician's progress report on July 6, 2015, the injured worker continues to experience low back and extremity pain. Examination of the lumbar spine demonstrated decreased range of motion with forward flexion at 40 degrees, extension at 10 degrees, bilateral lateral bending at 20 degrees each and bilateral rotation at 30 degrees each. Manual motor strength noted left knee extension at 4-/5. Paresthesias to light touch were documented in the lateral legs bilaterally. Achilles reflex were 1++ bilaterally. Sacroiliac joint compression and slump tests were positive bilaterally. Gait was functional. Current medications are listed as Tramadol ER 150mg and Cyclobenzaprine. Treatment plan consists of continuing with the functional restoration program (FRP), home exercise program and the current request for a lumbar support.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Support, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar Supports.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar Supports.

Decision rationale: The requested Lumbar Support, QTY: 1 is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Low Back Complaints, Page 301, note lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar Supports, also note Lumbar supports: Not recommended for prevention. Under study for treatment of non-specific LBP Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, or post-operative treatment. The injured worker has low back and extremity pain. Examination of the lumbar spine demonstrated decreased range of motion with forward flexion at 40 degrees, extension at 10 degrees, bilateral lateral bending at 20 degrees each and bilateral rotation at 30 degrees each. Manual motor strength noted left knee extension at 4-/5. Paresthesias to light touch were documented in the lateral legs bilaterally. Achilles reflex were 1++ bilaterally. Sacroiliac joint compression and slump tests were positive bilaterally. The treating physician has not documented the presence of spondylolisthesis, documented instability, or acute post-operative treatment. The criteria noted above not having been met, Lumbar Support, QTY: 1 is not medically necessary.