

Case Number:	CM15-0034135		
Date Assigned:	02/27/2015	Date of Injury:	12/27/2006
Decision Date:	04/10/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	02/23/2015

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: Preventive Medicine, Occupational 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 34 year old female, who sustained an industrial injury on 12/27/2006. The diagnoses have included bilateral lumbar myalgia, bilateral lumbar myospasm, bilateral lumbar radiculitis/neuritis and bilateral lumbar sprain/strain. Treatment to date has included physical therapy and medication. A progress note dated 10/15/2015 documented that the injured worker presented for follow-up status post left hip arthroscopic femoroplasty, acetabuloplasty, labral repair and synovectomy 8/2/2014. She noted 50% pain reduction from her pre-surgical state. Physical exam revealed positive pain on hip flexion with internal rotation and tenderness to palpation at the trochanteric bursa region. According to the Primary Treating Physician's Progress Report dated 12/15/2014, the injured worker complained of hip and groin pain, left knee pain and low back pain. Physical exam was noted to be unchanged. Treatment plan was to continue pain management for medications and low back pain. A Transcutaneous Electrical Nerve Stimulation (TENS) unit was recommended. On 2/5/2015, Utilization Review (UR) non-certified a request for Lumbar-Sacral Orthosis (LSO) Sag-Coronal panel prefabricated dispensed on 12/15/2014 for lumbar spine. The Medical Treatment Utilization Schedule (MTUS) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request: LSO sag-coronal panel prefabricated dispensed on 12/15/2014 for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 301, 340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: According to the MTUS, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Based on the patient's stated date of injury, the acute phase of the injury has passed. An LSO sag-coronal panel prefabricated dispensed on 12/15/2014 for the lumbar spine is not medically necessary.