

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0080915 | | |
| Date Assigned: | 05/01/2015 | Date of Injury: | 08/19/2014 |
| Decision Date: | 06/02/2015 | UR Denial Date: | 04/24/2015 |
| Priority: | Standard | Application Received: | 04/28/2015 |

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:

This 57 year old male sustained an industrial injury to the back, hands and hip on 8/19/14. Previous treatment included magnetic resonance imaging, physical therapy, acupuncture, chiropractic therapy, injections and medications. In an initial pain management evaluation dated 4/16/15, the injured worker complained low back pain with radiation to bilateral hips rated 7/10 on the visual analog scale and occasional hand pain. Current diagnoses included right hip strain, myofascial pain syndrome, lumbar spine disc displacement, lumbar spine radiculopathy, lumbar spine stenosis, lumbar spine sprain/strain and right greater trochanteric bursitis. The treatment plan included a prescription for Mobic and chiropractic therapy twice a week for four weeks. On 4/16/15, a request for authorization was submitted for a back brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Back brace: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Back brace, 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 nonspecific 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 pain with radiation to bilateral hips rated 7/10 on the visual analog scale and occasional hand pain. 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, Back brace is not medically necessary.

Chiropractic x 8: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation, Pages 58-59 Page(s): 58-59.

Decision rationale: The requested Chiropractic x 8, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The injured worker has low back pain with radiation to bilateral hips rated 7/10 on the visual analog scale and occasional hand pain. The treating physician has not documented objective evidence of derived functional benefit from completed chiropractic sessions, such as improvements in activities of daily living, reduced work restrictions or reduced medical treatment dependence. The criteria noted above not having been met, Chiropractic x 8 is not medically necessary.