

Case Number:	CM15-0118332		
Date Assigned:	06/26/2015	Date of Injury:	02/18/2011
Decision Date:	07/27/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	06/18/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 sustained an industrial injury on 2/18/2011 resulting in pain to the right forearm, neck, low back, and right shoulder. She has been diagnosed with right forearm pain, cervical sprain/strain, right shoulder sprain/strain, degenerative disc disease, and low back pain. Treatment has included medication, TENS unit, epidural steroid injections, and home exercise. The injured worker has reported symptom relief with regular use of the TENS unit, and steroid injections provide up to 50% pain relief. The injured worker continues to report ongoing back and shoulder pain. The treating physician's plan of care includes 12 physical therapy/massage therapy visits and soft neoprene thoracolumbar orthosis. She is working without restrictions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soft Neoprene Thoracolumbar Orthosis purchase: 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), Low Back & Lumbar & Thoracic (Acute & Chronic) Chapter (Online version).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 138-139.

Decision rationale: The claimant sustained a work injury in February 2011 and continues to be treated for low back and left wrist pain. When seen, there was lower lumbosacral spine tenderness with nearly full range of motion with mild pain. There was mild wrist tenderness with full range of motion. Authorization for 12 sessions of physical therapy and a soft lumbar support to be worn during the day while working was requested. Guidelines recommend against the use of a lumbar support other than for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. In this case, there is no spinal instability or other condition that would suggest the need for a lumbar orthosis and the claimant has not undergone surgery. Lumbar supports have not been shown to have lasting benefit beyond the acute phase of symptom relief and prolonged use of a support may discourage recommended exercise and activity with possible weakening of the spinal muscles and a potential worsening of the spinal condition. The requested lumbar support was not medically necessary.

Physical therapy/massage therapy times 12 for the lumbar spine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant sustained a work injury in February 2011 and continues to be treated for low back and left wrist pain. When seen, there was lower lumbosacral spine tenderness with nearly full range of motion with mild pain. There was mild wrist tenderness with full range of motion. Authorization for 12 sessions of physical therapy and a soft lumbar support to be worn during the day while working was requested. The claimant is being treated for chronic pain with no new injury. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended and is not medically necessary.