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| Case Number: | CM15-0127524 | | |
| Date Assigned: | 07/14/2015 | Date of Injury: | 03/14/2003 |
| Decision Date: | 08/10/2015 | UR Denial Date: | 06/11/2015 |
| Priority: | Standard | Application Received: | 07/01/2015 |

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 51-year-old male with an industrial injury dated 03/15/2002. His diagnoses included post laminotomy pain syndrome, chronic pain syndrome, left knee internal derangement, history of narcotic dependency, hypertensive cardiovascular disease, incontinence, gastroesophageal reflux disease, constipation and erectile dysfunction. Prior treatment included topical creams, antibiotics, perineural subcutaneous injections (no benefit) and peripheral percutaneous neurostimulation. He presented on 03/16/2015 post 4 treatments of peripheral field electrical neurostimulation for treatment of chronic pain syndrome with severe headaches, mood and sleep disorder. The injured worker's family report substantial improvement in his mood, sleep and energy level. Physical examination noted some improvement in mood and better eye contact. Lumbar spine range of motion was painful with tenderness and decreased range of motion. There was mild crepitus of the left knee joint with tenderness. The treatment request for cardiac echocardiogram was authorized. The request for review is lumbar spine support.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spine support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: According to MTUS guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. A lumbar corset is recommended for prevention and not for treatment. Therefore, the request for Lumbar support is not medically necessary.