

Case Number:	CM13-0002094		
Date Assigned:	12/27/2013	Date of Injury:	03/20/2009
Decision Date:	02/20/2014	UR Denial Date:	07/17/2013
Priority:	Standard	Application Received:	07/19/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pediatric Rehabilitation Medicine, and is licensed to practice in Illinois and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 71-year-old female who reported a work related injury on 03/20/2009 due to a trip and fall. The patient has undergone conservative therapy to include chiropractic therapy, physical therapy, and injections. Lumbar MRI revealed multilevel degenerative disc disease with some central canal stenosis, most severe at L3-4. The patient also underwent previous lumbar medial branch blocks and numerous trigger point injections without relief. The patient underwent a right knee replacement in 2008. A request has been made for lumbar/sacral orthosis/lumbar traction x1 and aqua therapy membership 5 times a week for 3 weeks per month for the right knee, back, right elbow and shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar-sacral orthosis/lumbar traction x 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, Low Back Section, lumbar supports

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Traction

Decision rationale: Recent clinical documentation stated the patient complained of soreness and aching to her right lower extremity. She also complained of lower back pain. Physical examination revealed excellent range of motion, full extension, and 120 degrees of flexion to the right knee. Ligaments were stable with mild crepitation noted with range of motion. Per submitted documentation, an authorization was requested for a lumbosacral brace/DDS 500 lumbar traction which was noted to be a spinal air decompression LSO with anterior and posterior rigid panels. There was no rationale provided in the submitted clinical documentation for the request for a lumbar traction unit. Official Disability Guidelines indicate that traction is not recommended using power traction devices, but home based patient controlled gravity traction may be a noninvasive conservative option if it is used as an adjunct to the program of evidence based conservative care to achieve functional restoration. The patient was not noted to be undergoing conservative care for her lumbar spine per submitted documentation. Guidelines further state that as a sole treatment, traction has not been proved efficacy for lasting relief in the treatment of low back pain. Therefore, the decision for lumbar/sacral orthosis/lumbar traction x1 is non-certified.

Aqua therapy membership 5 times a week for 3 weeks per month (duration not indicated) for the right knee, back, right elbow: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy. Decision based on Non-MTUS Citation ODG-TWC, Low Back Procedure Summary, and TriCare Guidelines Policy Manual

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy, physical Medicine Page(s): 22, 98-99.

Decision rationale: California Chronic Pain Medical Treatment Guidelines indicate that aquatic therapy is recommended as an optional form of exercise therapy as an alternative to land based physical therapy. Guidelines recommend 9 to 10 therapy visits over 8 weeks for myalgia and myositis. The duration for aqua therapy for the patient was not indicated in the request and the patient was not noted to have significant functional deficits or a need for reduced weight bearing to warrant aqua therapy sessions. As such, the decision for aqua therapy membership 5 times a week for 3 weeks per month is non-certified.