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| Case Number: | CM13-0006576 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 09/09/2011 |
| Decision Date: | 06/19/2014 | UR Denial Date: | 07/23/2013 |
| Priority: | Standard | Application Received: | 08/02/2013 |

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. The expert reviewer is Board Certified in Anesthesiology and Pain Medicine, and is licensed to practice in Florida. 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/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 injured worker is a 28-year-old male who reported an injury on 09/09/2011, while pushing a gurney. Current diagnoses include lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and left sacroiliac joint pain. The injured worker was evaluated on 07/03/2013. The injured worker reported 8/10 low back pain with radiation into the left lower extremity. Previous conservative treatment includes 8 sessions of physical therapy. Physical examination on that date revealed diffuse tenderness over the lumbar paraspinal musculature, moderate facet tenderness from L4-S1. Positive sacroiliac tenderness on the left, positive Fabere testing on the left, positive sacroiliac thrust testing on the left, positive Yeoman's testing on the left, positive straight leg raising on the left, and limited lumbar range of motion. Treatment recommendations included a cervical and lumbar traction unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR TRACTION UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Low Back Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. Official Disability Guidelines do not recommend using powered traction devices but home based patient controlled gravity traction may be a noninvasive conservative option if used as an adjunct to a program of evidence based conservative care to achieve functional restoration. As a sole treatment, traction has not been proven effective for lasting relief in treatment of low back pain. The injured worker has participated in a previous course of physical therapy and should be well versed in a home exercise program to manage presenting symptoms. There is no indication that this injured worker is currently participating in a program of evidence based conservative care to achieve functional restoration. Based on the clinical information received, the request is not medically necessary.