

Case Number:	CM13-0013422		
Date Assigned:	10/01/2013	Date of Injury:	12/07/1995
Decision Date:	01/17/2014	UR Denial Date:	07/18/2013
Priority:	Standard	Application Received:	08/16/2013

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 Internal Medicine and Cardiology has a subspecialty in Cardiovascular Disease and is licensed to practice in California. 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 a reported date of injury on 12/07/1995. The patient presented with recurrent low back pain and decreased thoracolumbar spine range of motion. The patient had no paralumbar tenderness or spasm. The patient had a negative seated straight leg raise bilaterally to 90 degrees. The patient's neurologic exam demonstrated no focal deficit and the patient denied any lower extremity radicular symptoms. The patient had diagnoses including recurrent lumbosacral musculoligamentous sprain/strain syndrome, moderately severe L5-S1 intervertebral disc degeneration, and disc protrusion of 5 mm at L5-S1. The physician's treatment plan included request for a home traction unit and chiropractic manipulation 2x3 if home traction unit was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

purchase of a home traction unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Procedure Summary

MAXIMUS guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Traction

Decision rationale: The California MTUS guidelines do not address lumbar spine traction. ACOEM states, traction is not recommended for the treatment of low back disorders. The Official Disability Guidelines further note, traction is not recommended 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 proved effective for lasting relief in the treatment of low back pain. It was noted within the documentation the patient obtained use of a home traction unit that was borrowed. Guidelines note the sole treatment of traction is not recommended. Within the provided documentation it was unclear if the patient would be utilizing the traction with an active physical therapy modality. Additionally, the physician did not include adequate documentation of significant objective functional improvement with the use of the traction unit. Therefore, the request for a home traction unit is neither medically necessary, nor appropriate.

chiropractic manipulation 2 x3 (if home traction unit is denied): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

Decision rationale: The California MTUS guidelines note chiropractic treatment is recommended for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The guidelines note chiropractic care of the ankle & foot, for carpal tunnel syndrome, of the forearm, wrist, & hand, and of the knee are not recommended. The guidelines recommend up to 4-6 treatments in order to produce effect and with evidence of objective functional improvement up to a maximum of 8 weeks of treatment. The guidelines recommend a frequency of 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition and treatment may continue at 1 treatment per week for the next 6 weeks. Within the provided documentation the requesting physician's rationale for the request was unclear. Additionally, the requesting physician did not include a complete and accurate assessment of the patient's full objective functional condition presently in order to demonstrate the patient's need for chiropractic care at this time. Therefore, the request for chiropractic manipulation 2x3 is neither medically necessary, nor appropriate.