

Case Number:	CM14-0150370		
Date Assigned:	09/18/2014	Date of Injury:	09/29/2011
Decision Date:	10/17/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/15/2014

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 Orthopedic Surgery and is licensed to practice in Arizona. 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:

This 44-year old male meat-cutter sustained injuries to left shoulder and lumbar spine after picking up a tray of chickens weighing 60-70 lbs on evening of 11/04/2012 leading to immediate pain. He was unable to contact his supervisor and decided, due to increasing discomfort to go directly to private healthcare facility and was seen by private physician on 9/30/2011. He was examined, prescribed pain medications, kept off work for 5 days and told to visit industrial clinic. He followed up with private physician who took him off for 20 more days. Eventually was able to report injury in October 2011 to his manager and was referred to clinic, where he underwent physical examination, had X-rays taken and treatment prescribed. He recently changed his primary physician. Treatment consisted of PT [2 times per week for 1-2 months--no documentation] with no improvement. He was returned to his regular duties and, although he tried to avoid heavy lifting, his symptoms persisted due to increased workload. His employer apparently did not honor his restrictions. He also elaborated on non-back injury [ies] sustained from 2004 to 2/15/2012. In December 2022, due to continuing symptoms, he underwent MRI's of left shoulder and lumbar spine and subsequently told that he needs shoulder surgery. Had shoulder surgery [2/15/2012] & has been out of work since then. March 2012 saw chiropractor and was treated with PT for low back pain. In 2002 he was advised by orthopedic surgeon to undergo low back surgery. In 2003 pain management saw him, did MRI [unknown area] and prescribed medications and ESI that helped for 2 weeks only. Subsequently developed depression and saw a psychologist [? detail]. He followed up with chiropractor until March 2014. Initial orthopedic evaluation [1/14/2013] was not available. His present complains [7/16/2014] consist of increasing low back pain [40%] & more [60%] left-sided leg pain. He has intermittent claudication radiating to both buttocks & lower legs. After walking for 2 blocks he notices weakness in his legs and tends to fall. He can continue after resting a while. Previous assessment

[4/17/2014] by initial primary treating physician only emphasized radiculopathy and designated musculo-ligamentous due to cumulative trauma as pathogenesis. Within scope of 'future medical care' outlined earlier, only includes low back and shoulder. Physical examination revealed tenderness low back, bilateral facet joints, sciatic notch and right sacroiliac joint. Neurologic assessment showed hypo-sensation left L5, S1 dermatomes, motor weakness lower extremities and positive straight leg raise assessment bilateral. Deep tendon reflexes lower extremities were not documented. Treatment rendered since day of injury: Medications: Anaprox; Flexeril; Norco [short term improvement.]; Ultram; Prilosec; and Ultracin. Treatments: Interferential unit; Acupuncture [June 2013] not helpful; PT [October 2011] and HEP (home exercise program); Shoulder surgery [2/15/2012]. Not beneficial., and Psychology consult [6/18/2013]. Diagnostic study consisted of MRI lumbar spine [7/15/2014] showing disc desiccation L2-Sacrum and Grade I spondylo-listhesis L4-5, mild spinal stenosis L3-4, L4-5 and L5-S1 according to the radiologist. Impression of the surgeon was critical lumbar spinal stenosis at L4-5 & L5-S1 and disc protrusions at levels L3-S1. No instability was found on flexion/extension radiographs. EMG / NCV studies previously showed radiculopathy [6/11/2014]. Most recent primary treating physician documented diagnosis as lower extremity neurogenic claudication due to lumbar spinal stenosis claudication and disc protrusions of the lumbar spine. Work status: Permanent and stationary, out of work since shoulder surgery [2/15/2012]. The UR denial was on 9/9/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

One lumbar traction purchase with installation fee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 210, 298-301 and 357. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Traction/Powered traction devices

Decision rationale: MTUS states that lumbar traction as a single entity, with or without powered traction devices, has not been proved clinically effective for lasting relief in the treatment of low back pain. The mechanism is supposed to rely on vertebral axial decompression but the evidence is insufficient and therefore is not recommended in treatment of low back pain. Home-based patient controlled gravity traction may be an option, if used as part of conventional conservative care to achieve functional restoration [under medical supervision]. This patient does not qualify for this modality of treatment and as such neither for the installation. ODG confirms this opinion and is also supported by more recent studies. Traction has not been shown to improve symptoms for patients with or without sciatica (Kinkade, 2007). As previously mentioned, powered traction devices are not recommended due to absence of evidence in support of it and, specifically in the case of vertebral axial decompression, the proof is insufficient to support its use in low back injuries. ACOEM indicates as well that traction as therapy show a lack of clinical efficacy for low back pain or radicular pain syndromes. Studies show no reduction in pain or other clinical

parameters and actually show that traction tend to enforce inactivity. Therefore traction is once again not recommended for treatment of low back pain or radiculopathy.