

Case Number:	CM14-0027898		
Date Assigned:	06/16/2014	Date of Injury:	08/02/2013
Decision Date:	07/24/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	03/05/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in California and Washington. 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 20-year-old who reported an injury on August 2, 2013 due to lifting an object. The injured worker had complaints of low back pain above right buttock and down left leg; pain level was 4/10. Physical examination on February 6, 2014 revealed difficulty with heel walking bilaterally. Moderate tenderness over the right posterior superior iliac spine. The injured worker lacked twelve inches from reaching his toes. Extension was to 14 degrees, lateral bending was to 26 degrees right, and 25 degrees left. Rotation was to 40 degrees bilaterally. Limited straight leg raising in a supine position was to 35 degrees right side, and 25 degrees left side. In a sitting position it was 80 degrees right, and 50 degrees left. Positive Lasegues bilaterally. MRI on August 20, 2013 revealed moderate to severe central stenosis at L4-L5 secondary to 13.0mm disc herniation compression bilateral L5 nerve roots. Moderate central stenosis at L3-L4 secondary to 8.0mm right paracentral disc herniation at L3-L4 compression the right L4 nerve root. Past treatments were physical therapy, therapeutic exercises, stretching, and nerve block injections. Medications were not listed on this visit. Past medications were Tylenol, Naprosyn, Ultracet, tizanidine. The treatment plans requested were inversion table for home use for two weeks for a trial basis, and rental of electrical stimulation unit for five months. The rationale was to document functional improvement. The request for authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inversion table for home use, for two weeks on a trial basis: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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, Traction.

Decision rationale: The request for inversion table for home use for two weeks trial basis is non-certified. The injured worker has had conservative care for low pain back with pain down left leg. Medications were given initially after the injury which were tylenol, naprosyn, ultracet and tizanidine. It was not noted if the injured worker had pain relief from these medications and how long were they taken for. The Official Disability Guidelines state that using powered traction devices are not recommended, 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 sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain. The evidence suggests that any form of traction may not be effective. The request does specify the type of traction such as continuous or intermittent, autotraction or mechanical traction. The frequency and duration were not on the request submitted. The request for inversion table for home use, for two weeks on a trial basis is not medically necessary or appropriate.

Rental of electrical stimulation unit for five months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114 and 115.

Decision rationale: The request for electrical stimulation unit for five months is non-certified. The request submitted does not state what type of electrical stimulation unit or the frequency of use. The California Medical Treatment Utilization Schedule states Transcutaneous electrotherapy is the most common form of electrotherapy where electrical stimulation is applied to the surface of the skin. TENS (transcutaneous electrical nerve stimulation) is the most common used. Not recommended as a primary treatment modality, but a one-month home based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration, for the conditions described. A home based treatment trial of one month may be appropriate for neuropathic pain and CRPS II, and for CRPS I, neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. The injured worker does not have any of those diagnoses. Therefore, the request for the rental of electrical stimulation unit for five months is not medically necessary or appropriate.