

Case Number:	CM14-0208199		
Date Assigned:	12/19/2014	Date of Injury:	04/13/2012
Decision Date:	02/28/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/11/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas, California
 Certification(s)/Specialty: Family Practice

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 is a 54 year old male patient who sustained a work related injury on 4/13/12. The exact mechanism of injury was not specified in the records provided. The current diagnosis includes lumbar strain. Per the doctor's note dated 5/7/14, patient has complaints of back pain on standing for prolonged periods of time and with activities. Physical examination revealed tenderness on palpation, limited range of motion, positive SLR, and normal sensory and motor examination. The current medication lists include Tylenol, cyclobenzaprine, tramadol, Theradon, Ibuprofen, and Gabapentin. The patient has had MRI of the lumbar spine 10/15/13 that revealed disc disease and protrusions at L2-L3 2.8 mm, L3-L4 2.4 mm; EMG and nerve conduction study in May 2014 that did not show radiculopathy and a sleep study. Any surgical or procedure note related to this injury were not specified in the records provided. Other therapy done for this injury was not specified in the records provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Unit Purchase with Electrodes, Conductive Back Garment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) is "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." Per the cited guideline "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: - Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or - Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." Per the records provided, any indication listed above is not specified in the records provided. The records provided do not specify a response to conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts for this injury. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. Detailed response to previous conservative therapy was not specified in the records provided. The previous PT visit notes are not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications is not specified in the records provided. The medical necessity of the request for Interferential Unit Purchase with Electrodes, Conductive Back Garment is not fully established in this patient.

Lumbar Therapy Kit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: Per the ACOEM guidelines cited below "Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms." The details of PT or other types of therapy done since the date of injury were not specified in the records provided. Detailed response to previous conservative therapy was not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. Any contraindication to a simple home exercise program without specialized equipment is not specified in the records provided. The rationale for the need of specialized equipment is not

specified in the records provided. Response to prior conservative therapy is not specified in the records provided. The medical necessity of the request for Lumbar Therapy Kit is not fully established in this patient.

Lumbar Traction Unit Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 01/30/15) Traction.

Decision rationale: As per cited guideline "Traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended" According the cited guidelines, "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." Therefore mechanical traction is has not been proved effective for lasting relief in the treatment of low back pain and is not recommended by the cited guideline. Detailed response to previous conservative therapy was not specified in the records provided. Prior conservative therapy visit notes were not specified in the records provided. The response of the symptoms to a period of rest, oral pharmacotherapy is not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use the traction unit as an adjunct to a program of evidence-based functional restoration. Any evidence of diminished effectiveness of medications or intolerance to medications (that would preclude the use of oral medications) was not specified in the records provided. The medical necessity of the request for Lumbar Traction Unit Purchase is not fully established in this patient.