MAXIMUS Federal Services

| Case Number: | CM15-0001920 | | |
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| Date Assigned: | 01/12/2015 | Date of Injury: | 01/17/2014 |
| Decision Date: | 04/03/2015 | UR Denial Date: | 12/08/2014 |
| Priority: | Standard | Application Received: | 01/05/2015 |

## 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: North Carolina
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:

The injured worker is a 40 year old male with an industrial injury dated 07/10/2014. The injured worker's complaints are pain in mid back region. The injured worker (IW) presented on 11/22/2014 for follow up on with complaints of intermittent, moderate, dull neck pain with stiffness and heaviness rated as 6/10 on a pain scale. He also complained of frequent, moderate, sharp upper and mid back pain and low back pain rated as 7/10 and described as constant, severe and sharp. Physical exam revealed tenderness to palpation of the bilateral trapezii and cervical paravertebral muscles. Soto-Hall was positive. There was tenderness to palpation noted of the thoracic paravertebral muscles and of the lumbar paravertebral muscles. Kemp's was positive. Diagnoses included cervical disc protrusion, cervical muscle spasm, cervical sprain/ strain, thoracic sprain/strain, lumbar sprain/strain, anxiety and depression. Prior treatments consisted of chiropractic treatments, acupuncture, physiotherapy and extracorporeal shockwave treatments. On 12/08/2014 Utilization Review non - certified the request for cervical traction noting there is no documentation of any clinical condition for which use of this device is medically necessary. There is no documentation of trial use in therapy and significant functional benefit of this device that would warrant home use. MTUS (Traction -mechanical) guidelines were cited. On 01/05/2015 the injured worker submitted an application for IMR review of the requested cervical traction.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical traction system:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) traction.

**Decision rationale:** Per the Official Disability Guidelines section on traction: Not recommended using power 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 proved effective for lasting relief in the treatment of back pain. Per the ACOEM chapter on neck complaints: There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living. The requested service is a recommended treatment option for the treatment of cervical neck pain/radiculopathy. However the recommendations are for it to be used in adjunct to a program of evidence based conservative care. The provided documentation does not specify, besides medications, what adjunctive conservative therapy will be used with this patient. The patient has previously completed physical therapy, TENS unit and aqua therapy but there is no mention of continuation of therapy or a home exercise program transition. Therefore all criteria for the use of home traction have not been met and the request is not certified.