

Case Number:	CM15-0168087		
Date Assigned:	09/08/2015	Date of Injury:	10/04/2012
Decision Date:	10/07/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	08/26/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 50 year old female, who sustained an industrial-work injury on 10-4-12. She reported initial complaints of neck pain. The injured worker was diagnosed as having cervical degenerative disc disease and cervical spondylosis. Treatment to date has included medication. MRI results were reported on 3-12-15. Currently, the injured worker complains of pain in the right shoulder, neck, and low back. Pain was described as sharp and aching and rated as 8 out of 10 and worsening in the shoulder and low back. There were constant headaches and flare ups in the neck. Sleep was affected due to pain. Per the primary physician's progress report (PR-2) on 7-9-15, objective findings noted right shoulder, neck, and low back tenderness and spasm. Range of motion was normal in the shoulder. The elbow and forearm exam noted positive Cozen's sign, Mills test, medial epicondyle tenderness and lateral epicondyle tenderness in the right elbow. The cervical spine had reduced range of motion. The lumbar spine noted moderate paraspinal tenderness and spasms bilaterally and limited range of motion. Current plan of care included diagnostic testing, analgesics, and chiropractic treatment request. The requested treatments include Functional Restoration Program, Shockwave Treatment for the lumbar spine, and Saunders Home Cervical Traction Unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional restoration program, twice weekly for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Chronic pain programs (functional restoration programs).

Decision rationale: Recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below. Also called Multidisciplinary pain programs or Interdisciplinary rehabilitation programs, these pain rehabilitation programs combine multiple treatments, and at the least, include psychological care along with physical therapy & occupational therapy (including an active exercise component as opposed to passive modalities). While recommended, the research remains ongoing as to (1) what is considered the "gold-standard" content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. These treatment modalities are based on the bio-psychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005) There appears to be little scientific evidence for the effectiveness of multidisciplinary bio-psychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pretreatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel, 2005) Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower grades of CLBP, according to the results of a prospective longitudinal clinical study reported in the December 15 issue of Spine. (Buchner, 2007) See also Chronic pain programs, early intervention; Chronic pain programs, intensity; Chronic pain programs, opioids; and Functional restoration programs. Criteria for the general use of multidisciplinary pain management programs: "Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: 1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may

be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed." There is no recent documentation of a comprehensive evaluation of the patient for a functional restoration program with failure of conservative therapies as well as other therapies. Furthermore, there is no recent documentation of the patient motivation to attend a functional restoration program. Therefore, the request for Functional Restoration Program x8 is not medically necessary.

Shockwave treatment for the lumbar spine, once weekly for three weeks: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shock wave therapy. <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, shockwave therapy "Not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. (Seco, 2011)". Therefore, the request for Shockwave treatment for the lumbar spine, once weekly for three weeks is not medically necessary.

Saunders Home cervical traction unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Traction (mechanical) <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, inversion table (Traction (mechanical)). "Recommend home cervical patient controlled traction (using a seated over-the-door device or a supine device, which may be preferred due to greater forces), for patients with radicular symptoms, in conjunction with a home exercise program. Not recommend institutionally based powered traction devices. Several studies have demonstrated that home cervical traction can provide symptomatic relief in over 80% of patients with mild to moderately severe (Grade 3) cervical spinal syndromes with radiculopathy. (Aetna, 2004) (Olivero, 2002) (Joghataei, 2004) (Shakoor, 2002) Patients receiving intermittent traction performed significantly better than those assigned to the no traction group in terms of pain, forward flexion, right rotation and left rotation. (Zylbergold, 1985) Other studies have concluded there is limited documentation of efficacy of cervical traction beyond short-term pain reduction. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. (Kjellman, 1999) (Gross-Cochrane, 2002) (Aker, 1999) (Bigos, 1999) (Browder, 2004) This Cochrane review found no evidence from RCTs with a low potential for bias that clearly supports or refutes the use of either continuous or intermittent traction for neck disorders. (Graham, 2008) The Pronex and Saunders home cervical traction devices are approved for marketing as a form of traction. Although the cost for Pronex or Saunders is more than an over-the-door unit, they are easier to use and less likely to cause

aggravation to the TMJ. Therefore, these devices may be an option for home cervical traction. (Washington, 2002) For decades, cervical traction has been applied widely for pain relief of neck muscle spasm or nerve root compression. It is a technique in which a force is applied to a part of the body to reduce paravertebral muscle spasms by stretching soft tissues, and in certain circumstances separating facet joint surfaces or bony structures. Cervical traction is administered by various techniques ranging from supine mechanical motorized cervical traction to seated cervical traction using an over-the-door pulley support with attached weights. Duration of cervical traction can range from a few minutes to 30 min, once or twice weekly to several times per day. In general, over-the-door traction at home is limited to providing less than 20 pounds of traction. See also Manual traction. Recent research: Recent studies have documented good results using traction to treat cervical radiculopathy with traction forces from 20 to 55 lbs (more than an over-the-door unit can provide). Cervical traction should be combined with exercise techniques to treat patients with neck pain and radiculopathy. (Raney, 2009) In comparing the intervertebral separation obtained with supine pneumatic traction (using the Saunders Cervical Traction Device) to seated traction (using an over-the-door home traction device), the supine device caused significantly greater separation vs. over-the-door traction. (Fater, 2008) In reviewing the current published evidence, this guideline concluded that cervical traction is recommended to treat cervical radiculopathy using greater than 20 lbs intermittent force. (Childs, 2008)" There is no clear documentation of cervical radiculopathy and there is no documentation of the use of cervical traction during physical. Therefore, the request for Saunders Home cervical traction unit is not medically necessary.