

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0145120 | | |
| Date Assigned: | 09/24/2014 | Date of Injury: | 09/08/2009 |
| Decision Date: | 10/24/2014 | UR Denial Date: | 08/26/2014 |
| Priority: | Standard | Application Received: | 09/08/2014 |

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 a 53-year-old male who reported a date of injury of 09/08/2009. The mechanism of injury was reported as a fall. The injured worker had diagnoses of lumbar disc injury, lumbar facet arthralgia, left sciatica, and left popliteal bursitis. Prior treatments included physical therapy and epidural steroid injections. Diagnostic studies were not indicated within the medical records provided. Surgeries included a left elbow surgery in 2009 and a revision in 2010. The injured worker had complaints of low back pain with radiation into the lower left extremity, describing the pain as a burning sensation. The clinical note dated 08/19/2014 noted the injured worker had a bilateral seated straight leg raise of 90 degrees with no referral to the lower extremities; however, experienced left buttock pain with the maneuver. There was moderate pain over the injured workers Lumbar spine, right more than the left of the L5-S1, L4-5, and right sacroiliac joint area. The injured worker had complete range of motion in all directions of the lumbar spine with moderate pain in forward flexion, extension, right lateral flexion, and right rotation. Motor strength was 5/5 throughout the lower extremities bilaterally and had complete intact sensation to light touch and pin prick. Medications included Lidoderm patches, tramadol, Celebrex, and Ambien. The treatment plan included Robaxin, tramadol, changing Celebrex to Relafen, and the physician's recommendation for additional sessions of physical therapy. The rationale was indicated as physical therapy had been helpful to the injured worker and 2 additional sessions of physical therapy were being requested in order to instruct the injured worker on the use of a home traction unit to determine if there was any way he could use it with better effectiveness. The Request for Authorization form was not provided within the medical records received.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 Additional Physical Therapy Visits for Home Traction Instruction Lumbar Spine Per 8/19/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Traction.

Decision rationale: The request for 2 additional physical therapy visits for home traction instruction, lumbar spine, per 08/19/2014, quantity 2, is not medically necessary. The injured worker had complaints of low back pain with radiation into the lower left extremity, describing the pain as a burning sensation. The California MTUS Guidelines recommend physical therapy as an active therapy based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapy at home as an extension of the treatment process in order to maintain improvement levels. The guidelines recommend 8 to 10 visits over 8 weeks, allowing for a fading of treatment frequency from up to 3 or more visits per week to 1 or less, plus active self-directed home physical therapy. Furthermore, the guidelines recommend traction as a home based patient controlled gravity traction as a noninvasive conservative option, if used in 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. There is a lack of documentation indicative of when the injured worker received the home traction unit and if adequate instructions for its use were provided to the injured worker. There is a lack of documentation indicative of the home traction unit being ineffective prior to the 08/19/2014 examination. Furthermore, there is a lack of documentation whether or not the physical therapist prescribed the home traction unit, and if the injured worker was informed on the use of the traction unit or the extent of how to use the traction unit. As such, the request is not medically necessary.