MAXIMUS Federal Services

Case Number:	CM14-0110795		
Date Assigned:	08/01/2014	Date of Injury:	03/27/2008
Decision Date:	07/16/2015	UR Denial Date:	07/10/2014
Priority:	Standard	Application Received:	07/16/2014

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 44 year old male, who sustained an industrial injury on 3/27/2008. Diagnoses include post laminectomy syndrome cervical region, degenerative disc disease cervical, chronic pain syndrome, neck pain, numbness, muscle pain and ulnar neuropathy. Treatment to date has included diagnostics, surgical intervention (level 3 fusion undated), cervical epidural steroid injections and medications including NSAIDs, proton pump inhibitors and topical creams. Magnetic resonance imaging (MRI) of the cervical spine dated 2/2012 showed a right paracentral disc protrusion causing narrowing of the right side cervical canal. Per the Primary Treating Physician's Progress Report dated 6/27/2014, the injured worker reported chronic neck pain and right shoulder pain due to disc herniation from a motor vehicle accident. He rates his pain as 8/10 without medication and 6/10 with medication. Physical examination of the cervical spine revealed 5/5 bilateral upper extremity strength. Sensation was intact and equal. Spurling's sign was positive on the right. There was tenderness over the cervical paraspinals and facet joints on the right with reduced range of motion in all planes. The plan of care included, and authorization was requested for traction unit for the neck and H wave repair and supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Traction unit for the neck: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back (Acute & Chronic) Cervical traction.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Traction, page 173.

Decision rationale: Per ACOEM Treatment Guidelines for the upper back and neck, there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction. Per ODG, cervical traction is recommended for patients with radicular findings, in conjunction with a home exercise program, not seen here. In addition, 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. Submitted reports have not demonstrated the indication or medical necessity for this traction unit. The Traction unit for the neck is not medically necessary and appropriate.

H-Wave repair and supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, H-Wave Stimulation, pages 115-118.

Decision rationale: Submitted reports have not provided any specific decreasing dose of medications or increase in ADLs as a result of the H-wave unit trial. There is no change in work status or functional improvement demonstrated to support for this unit. The MTUS guidelines recommend a one-month HWT rental trial to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function. The patient has had an H-wave trial use without any documented consistent pain relief in terms of decreasing medication dosing and clear specific objective functional improvement in ADLs have not been demonstrated. There is also no documented failed trial of TENS unit nor any indication the patient has a home exercise program for adjunctive exercise towards a functional restoration approach per submitted report by the provider. The H-Wave repair and supplies is not medically necessary and appropriate.