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| Case Number: | CM15-0173241 | | |
| Date Assigned: | 10/02/2015 | Date of Injury: | 12/27/2014 |
| Decision Date: | 11/13/2015 | UR Denial Date: | 08/05/2015 |
| Priority: | Standard | Application Received: | 09/02/2015 |

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: 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 35 year old male, who sustained an industrial injury on 12-27-2014. He has reported injury to the neck, right shoulder, and low back. The diagnoses have included cervical spine musculoligamentous sprain-strain with right upper extremity radiculitis; right shoulder periscapular strain, tendinitis, and impingement; lumbar spine musculoligamentous sprain-strain with right-sided sacroiliac joint sprain and right lower extremity radiculitis; and facet changes from L4 through S1, two-to-three millimeter disc bulge with neuroforaminal stenosis at L4-L5 and one-to-two millimeter disc bulge at L5-S1, per MRI. Treatment to date has included medications, diagnostics, activity modification, home muscle stimulation unit, chiropractic therapy, and physical therapy. Medications have included Motrin, Norco, and Gabapentin. A progress report from the treating provider, dated 06-11-2015, documented an evaluation with the injured worker. The injured worker reported improvement of low back pain and spasm of right lower extremity pain with each of the four treatments (mechanical traction); he is able to tolerate activities of daily living and exercise after treatment; and persistent neck pain. Objective findings included tenderness to the lumbar spine paravertebral muscles, right gluteal, and right sacroiliac regions; low back pain radiates to the right buttock and thigh; tenderness to the cervical spine paravertebral muscles and trapezii, right greater than left; and positive muscle guarding and axial compression. The treatment plan has included the request for one home lumbar mechanical traction unit. The original utilization review, dated 08-05-2015, non-certified the request for one home lumbar mechanical traction unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

One home lumbar mechanical 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, Low Back - Lumbar & Thoracic (Acute & Chronic) Traction 2015.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, under Traction.

Decision rationale: The patient presents with low back pain radiating to the bilateral lower extremities. The request is for ONE HOME LUMBAR MECHANICAL TRACTION UNIT. Physical examination to the lumbar spine on 03/17/15 revealed tenderness to palpation to the paravertebral muscles. Straight leg raising test was positive on the right. Range of motion was noted to be decreased. Per 02/06/15 progress report, patient's diagnosis include cervical spine musculoligamentous sprain/strain with right upper extremity radiculitis; right shoulder periscapular strain, tendinitis and impingement; lumbar spine musculoligamentous sprain/strain with right sided sacroiliac joint sprain and right lower extremity radiculitis, facet changes from L4 through S1, and two to three millimeter disc bulge with neuroforaminal stenosis at L4-L5 and one to two millimeter disc bulge at L5-S1, per MRI scan dated April 22, 2010. Patient's work status is modified duties. MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12, Low Back Complaints, page 300, under Physical Methods states: 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. ODG Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, under Traction states: "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. The patient continues with low back pain that radiates to the bilateral lower extremities and has a diagnosis of lumbar spine musculoligamentous sprain/strain with right sided sacroiliac joint sprain and right lower extremity radiculitis. Treater has not specifically addressed this request nor discussed whether the requested mechanical unit will be "used as an adjunct to a program of evidence-based conservative care," as indicated by ODG. ODG also states "As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain." In addition, ACOEM states "Traction has not been proved effective for lasting relief in treating low back pain." This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.