

Case Number:	CM15-0029787		
Date Assigned:	02/23/2015	Date of Injury:	06/22/2012
Decision Date:	07/24/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/17/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 42-year-old female who sustained a work related injury June 22, 2012. According to a follow-up report and request for surgical authorization, of the primary treating physician, dated December 10, 2014, the injured worker presented with residual neck pain s/p 2-level cervical arthrodesis. She also reports lower back pain radiating to the left hip and buttock as well as the left lower extremity with numbness and weakness. She continues to have left sided shoulder pain with decreased range of motion and weakness. Physical examination revealed; spasm, tenderness and guarding in the paravertebral musculature of the cervical and lumbar spine with decreased range of motion on flexion and extension. Decreased sensation is noted over the L3 dermatome on the left side with pain. Well-healed scars are noted over the cervical spine and left hip from bone grafting. Positive impingement and Hawkin's signs are noted in the left shoulder with less than 90 degrees of abduction and 100 degrees of forward flexion. Deltoid strength is graded 4/5 and positive active O'Brien's compression test is noted. Diagnoses are shoulder labrum tear; cervical radiculopathy; shoulder/elbow/wrist, tendonitis/bursitis. Treatment plan included a request for left shoulder arthroscopy, subacromial decompression, labral repair and possible left shoulder rotator cuff repair, which was authorized and expires on 04/26/2015. At issue, is the request for authorization for lumbar traction and a stationary bike.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Lumbar traction: 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), Lumbar & Thoracic, Acute & Chronic, Traction.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic), Traction.

Decision rationale: The claimant sustained a work injury in April 2014 is being treated for neck, left shoulder, and radiating low back pain. When seen, she was having back pain radiating into the left hip and lower extremity. She was having left sided shoulder pain. There was decreased spinal range of motion with paraspinal muscle tenderness, spasm, and guarding. There was decreased left lower extremity sensation. Shoulder impingement testing was positive and there was left shoulder weakness. The claimant has had physical therapy for the cervical spine. In terms of lumbar traction, 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. In this case, the type of traction being requested was not specified. The request is not medically necessary.

Associated Surgical Service: Stationary bike: 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) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant sustained a work injury in April 2014 is being treated for neck, left shoulder, and radiating low back pain. When seen, she was having back pain radiating into the left hip and lower extremity. She was having left sided shoulder pain. There was decreased spinal range of motion with paraspinal muscle tenderness, spasm, and guarding. There was decreased left lower extremity sensation. Shoulder impingement testing was positive and there was left shoulder weakness. The claimant has had physical therapy for the cervical spine. In this case, a trial of physical therapy for the lumbar spine appears indicated. Guidelines recommend a six visit clinical trial with a formal reassessment Compliance with a home exercise program would be expected and would not require specialized equipment. An exercise bike for home use is not medically necessary.