

Case Number:	CM15-0077375		
Date Assigned:	06/04/2015	Date of Injury:	08/10/1999
Decision Date:	07/02/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	04/22/2015

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, 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:

This 59 year old male sustained an industrial injury on 8/10/99. He subsequently reported back pain. Diagnoses include sciatica and chronic low back pain. Treatments to date include x-ray and MRI testing, chiropractic care, physical therapy and prescription pain medications. The injured worker continues to experience low back pain. Upon examination, there is antalgic posture while walking with slight forward inclination at the waist. Reduced range of motion and positive Minor's sign was noted. A request for two traction, four myofascial release and four electro-stim was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Two traction: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Traction.

Decision rationale: Regarding the request for traction, CA MTUS states that traction has not been proved effective for lasting relief in treating low back pain. ODG cites that it is 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. Within the documentation available for review, there is no indication that a patient-controlled gravity traction device will be used as an adjunct to other evidence-based care for the purpose of functional restoration. In light of the above issues, the currently requested traction is not medically necessary.

Four electro-stim: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (NMES).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) page(s): 114-121 of 127.

Decision rationale: Regarding the request for electro-stim, Chronic Pain Medical Treatment Guidelines do provide limited support for some forms of electrical stimulation such as TENS in the management of chronic pain after a successful trial. However, other forms of electrical stimulation such as NMES are not supported. Within the documentation available for review, there is no indication of the specific type(s) of electrical stimulation proposed such that the appropriate guideline criteria can be applied. In the absence of clarity regarding those issues, the currently requested electro-stim is not medically necessary.

Four myofascial release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints page(s): 146.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) page(s): 60 of 127.

Decision rationale: Regarding the request for myofascial release, Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, there is no indication as to the number of prior sessions the patient has previously undergone and any objective functional improvement from those sessions. Additionally, there is no indication that the currently requested massage therapy will be used as an adjunct to other recommended treatment modalities such as adherence to an independent home exercise program. Finally, it is unclear exactly what objective treatment goals are hoping to be addressed with the currently requested therapy. In the absence of clarity regarding those issues, the currently requested myofascial release is not medically necessary.