

Case Number:	CM15-0099046		
Date Assigned:	06/01/2015	Date of Injury:	11/03/2006
Decision Date:	07/03/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/22/2015

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:

The injured worker is a 62 year old female who reported an industrial injury on 11/3/2006. Her diagnoses, and/or impressions, are noted to include: cervical and lumbar spine sprain/strain, and radiculopathy; bilateral shoulder impingement syndrome; left ankle sprain/strain with degenerative joint disease; and right knee (illegible). No current imaging studies are noted. Her treatments have included medication management and rest from work. The progress notes of 4/20/2015 were hand written and mostly illegible, but noted complaints of the right cervical spine with radiation, and lumbar spine with bilateral ankle and occasional cramping to the bilateral feet. The objective findings were noted to include tenderness to palpation of the cervical and lumbar spine muscles, with spasms; decreased cervical spine lordosis; positive axial compression and straight leg raise tests; and that the injured worker is not working. The physician's requests for treatments were noted to include magnetic resonance imaging studies of the lumbar and cervical spine to rule-out disc pathology, and the purchase of home medical equipment for cervical and lumbar traction, and interferential conductive garment to reduce pain and work restrictions.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-4.

Decision rationale: Regarding the request for lumbar MRI, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery an option. Within the documentation available for review, there is no legible identification of any objective findings that identify specific nerve compromise on the neurologic exam suggestive of the need for MRI. In the absence of clarity regarding those issues, the currently requested lumbar MRI is not medically necessary.

Home Interferential unit with conductive garment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120 of 127.

Decision rationale: Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation as outlined above. Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.

Cervical spine traction: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-4. Decision based on Non-MTUS Citation X Official Disability Guidelines (ODG), Neck & Upper Back Chapter, Traction.

Decision rationale: Regarding the request for cervical spine traction, Occupational Medicine Practice Guidelines state that there is no high-grade scientific evidence to support the use of traction. They go on to state the traction is not recommended. ODG states that home cervical traction is recommended for patients with radicular symptoms, in conjunction with a home exercise program. They go on to state that powered traction devices are not recommended. Additionally, they do not recommend continuing the use of these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. Within the documentation available for review, there is no legible indication that the patient would be utilizing a trial of a patient-controlled traction device in conjunction with a home exercise program and, unfortunately, there is no provision for modification of the current request. In the absence of clarity regarding those issues, the currently requested cervical spine traction is not medically necessary.

lumbar spine traction: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 14-147, 300.

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

Decision rationale: Regarding the request for lumbar spine traction, Occupational Medicine Practice Guidelines state traction has not been proved effective for lasting relief in treating low back pain. ODG states traction 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 information made available for review, there is no indication that the requested lumbar traction unit is a patient-controlled device and that it will be used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. In the absence of such documentation, the currently requested lumbar spine traction is not medically necessary.