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**Notice of Independent Medical Review Determination**

Dated: 11/26/2013

[REDACTED]

[REDACTED]

Employee:

[REDACTED]

[REDACTED]

Date of UR Decision:

7/9/2013

Date of Injury:

1/17/2013

IMR Application Received:

7/19/2013

MAXIMUS Case Number:

CM13-0002177

- 1) MAXIMUS Federal Services, Inc. has determined the request for **12 physical therapy visits for the cervical spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **home cervical traction unit on a rental basis is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **TENS unit for home use is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/19/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/24/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **12 physical therapy visits for the cervical spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **home cervical traction unit on a rental basis is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **TENS unit for home use is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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 treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

The patient is a 30-year-old male who reported a work-related injury on 01/17/2013 as a result of a motor vehicle accident. The patient presents with the following diagnoses: cervical stenosis; cervicgia; left arm pain; lumbago; and lumbar degenerative disc disease. A clinical note dated 03/12/2013 reports the patient was seen under the care of [REDACTED] for his pain complaints. The provider documented the patient has utilized some physical therapy which had provided him with no relief. A clinical note dated 06/24/2013 reflects the patient was seen for followup under the care of [REDACTED]. The provider documented the patient reported physical therapy interventions were effective, especially after traction; however, pain reoccurs later the same day as treatment. The provider documented the patient had attempted use of multiple anti-inflammatories all of which upset the patient's stomach. Subsequently, the provider recommended physical therapy 12 visits for cervical stabilization specifically to include mechanical traction, a home traction unit, a TENS unit for home use, and electrodiagnostic studies of the left upper extremity. The current request previously received an adverse determination on 07/09/2013.

## Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review
- Utilization Review from Claims Administrator
- Medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

### 1) Regarding the request for 12 physical therapy visits for the cervical spine:

#### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS, and the ODG, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8, page 174, which is part of the MTUS, and the Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Physical Therapy Guidelines, which are not part of the MTUS.

#### Rationale for the Decision:

The ODG indicates that cervicalgia or cervical spondylosis should be treated with 9 visits over 8 weeks. In addition, the ODG recommends patients should be formally assessed after a six-visit clinical trial to see if the patient is moving in a positive direction, no direction, or a negative direction prior to continuing with the physical therapy. The employee's records do not include evidence of positive efficacy from previous physical therapy interventions, as the clinic notes indicate effectiveness while the patient was receiving treatment, but reoccurrence of onset of pain later the same day of treatment. Therefore, due to the lack of significant objective functional improvement and the request exceeding ACOEM and ODG guideline recommendations, the additional physical therapy visits for the cervical spine are not medically necessary. **The request for 12 physical therapy visits for the cervical spine is not medically necessary and appropriate.**

### 2) Regarding the request for a home cervical traction unit on a rental basis:

#### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS, and the ODG, which is not part of the MTUS.

The Expert Reviewer relied on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition, (2004), Neck and

Upper Back Complaints, pages 173, 181 and Table 8-8, which are part of the California MTUS.

Rationale for the Decision:

The ACOEM guidelines do not recommend the use of cervical traction. There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living. Further, the records submitted and reviewed lack evidence of significant objective functional improvements with the employee's utilization of traction in the physical therapy setting. **The request for a home cervical traction unit on a rental basis is not medically necessary and appropriate.**

**3) Regarding the request for a TENS unit for home use:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS, and the ODG, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 114.

Rationale for the Decision:

The Chronic Pain Medical Treatment Guidelines indicate a one-month trial period of the TENS unit should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Rental would be preferred over purchase during this trial. There is a lack of documentation evidencing the employee has utilized a trial of this intervention for pain complaints, and demonstrated efficacy of treatment including objective functional improvement and a decrease in rate of pain on a VAS scale. **The request for TENS unit for home use is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
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Oakland, CA 94612

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