

<b>Case Number:</b>	CM13-0067622		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	06/04/2001
<b>Decision Date:</b>	05/20/2014	<b>UR Denial Date:</b>	11/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 46-year-old female who reported an injury on 06/04/2001, due to repetitive trauma. The injured worker sustained an injury to the neck and bilateral upper extremities. The injured worker's treatment history included physical therapy, injection therapy, surgical intervention, and a work hardening program. The injured worker was evaluated on 10/07/2013. It was documented that the injured worker had continued left wrist and left hand pain. Evaluation of the left hand documented tenderness to palpation over the radial side in a positive Finkelstein's test and 4/5 motor strength. The injured worker's diagnoses included wrist pain and radial styloid tenosynovitis. The injured worker's treatment plan included continuation of medications. A request was made on 11/21/2013 for a mechanical cervical traction device to be used 15 minutes at a time as needed. However, no justification for the request was provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MECHANICAL CERVICAL TRACTION DEVICE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OGD TWC Neck & Upper Back Procedure Summary

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Traction

**Decision rationale:** The Official Disability Guidelines recommend cervical traction for injured workers with neck pain and radiculopathy. The injured worker's most recent clinical evaluation did not provide any evidence of an evaluation of the neck to support cervical deficits that would require this type of treatment. There is no documentation of cervical spine pain or radiculopathy. Additionally, the request as it is submitted does not clearly define a duration or frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested mechanical cervical traction device is not medically necessary and appropriate.