

<b>Case Number:</b>	CM14-0019586		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	02/01/2000
<b>Decision Date:</b>	07/03/2014	<b>UR Denial Date:</b>	02/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2014

### 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, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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 61 year old female with an injury reported on 02/01/2000. The mechanism of injury was described as cradling a phone in neck with her head in an awkward position. The clinical note dated 01/21/2014, reported the injured worker complained of pain in the cervical spine, which was rated 9/10 and described as sharp. The physical examination to the injured worker's cervical spine reported mild tenderness over the paravertebral musculature extending to both trapezius muscles with spasms. It was also noted that the injured worker had facet tenderness per palpation at C4-C7. The cervical spine range of motion was demonstrated flexion to 20 degrees, extension up to 30 degrees, right and left lateral flexion 30 degrees, right cervical rotation up to 60 degrees and left cervical rotation up to 70 degrees. The injured worker's diagnoses included thyroid disease, bilateral carpal tunnel release surgery in 2006 and 2007. The request for authorization was submitted on 02/15/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CERVICAL TRACTION UNIT FOR HOME USE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG NECK.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

**Decision rationale:** The request for cervical traction unit for home use is not medically necessary. The injured worker complained of cervical spine pain and examination revealed tenderness over the paravertebral musculature extending to both trapezius muscles with spasms, also with facet tenderness per palpation at C4-C7. According to American College of Occupational and Environmental Medicine (ACOEM) guidelines state that 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 neurological stimulation (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. The requesting provided does not specify on specific traction for utilization. The administration of cervical traction technique can be either supine mechanical motorized cervical traction, or an over-the-door pulley support with attached weights. According to the Official Disability Guidelines in regards to cervical traction suggest that recent studies have documented good results using traction to treat cervical radiculopathy with traction forces from 20 to 55 lbs. (more than an over-the-door unit can provide). Cervical traction should be combined with exercise techniques to treat patients with neck pain and radiculopathy. There is a lack of clinical information provided to determine the provider's rationale for the request and which specific variation of cervical traction being requested. It was unclear if the device would be utilized with exercise techniques. Therefore, the request for cervical traction unit for home use is not medically necessary.

**BILATERAL C5-6, C6-7 TRANSFACET EPIDURAL INJECTION (X2):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

**Decision rationale:** The request for bilateral C5-6, C6-7 transfacet epidural injection times 2 is not medically necessary. The injured worker complained of pain in the cervical spine, with a rated 9/10 pain described as sharp. According to California MTUS guidelines the purpose of epidural steroid injection is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The guidelines recommend injured workers should be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). The guidelines continue to suggest Injections should be performed using fluoroscopy (live x-ray) for guidance. If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. In the therapeutic phase, repeat

blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. Per clinical documentation the provider noted the injured worker had radiating pain to trapezius muscles, and a MRI dated 10/30/2013 reported C6-C7 disc protrusions with abutment of the exiting cervical nerve roots. The MRI also noted the C5-C6 level with degenerative changes and no disc protrusion. The injured worker's prescribed medication list included motrin, lidoderm patch and lorazepam. There is a lack of clinical information provided of medication effectiveness to pain, rating and of pain prior to medication. The requesting provider did not provide adequate clinical documentation of unresponsiveness to physical therapy and home exercises. There is also a lack of clinical documentation indicating the injured worker had significant objective findings congruent with radiculopathy. Therefore, the request for bilateral C5-6, C6-7 transfacet epidural injection times 2 is not medically necessary.