

Case Number:	CM14-0113040		
Date Assigned:	08/01/2014	Date of Injury:	12/28/2009
Decision Date:	09/10/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/21/2014

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 Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 37-year-old female who reported an injury on 12/28/2009 due to an unknown mechanism. The diagnoses were cervical disc disease and cervical radiculopathy. Past treatment was an epidural steroid injection on 05/08/2014 with an 85% reduction in pain. Diagnostic studies reported were a cervical MRI. Past surgeries were not reported. Physical examination on 06/04/2014 revealed complaints of neck pain which she rated at 3/10. The pain was described as dull, radiated to the bilateral shoulders but did not radiate down to the arms. The injured worker stated she was able to sleep longer periods of time. Examination of the cervical spine revealed midline with abnormal lordosis. There was mild tenderness noted over the cervical paravertebral musculature extending to both trapezius muscles with spasm. Spurling's sign was positive bilaterally. There was tenderness to palpation noted over the C5 through C7 spinous processes. Cervical spine range of motion flexion was to 25 degrees, extension was to 55 degrees, lateral flexion to the right was 30 degrees, lateral flexion to the left was to 30 degrees, lateral rotation to the right was 60 degrees, and lateral rotation to the left was 70 degrees. Sensory examination was grossly intact with all dermatomes to pain, temperature, light touch, vibration, and 2 point discrimination, except at the right C6-7 and left C7 dermatomes. Treatment plan was for cervical C5 through C7 epidural with catheterization, also to continue medications as directed, cervical traction unit, and an H-wave unit for home use. Medications were not reported. The rationale and request for authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) Second C5 -C7 Epidural with Catheterization: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend for repeat epidural steroid injection, there must be objective documented pain relief and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. The injured worker's medications were not reported. The provider submitted range of motion values for the cervical spine and the shoulders but did not submit range of motion values from a progress note prior to the epidural steroid injection for comparison. Therefore, the request for One (1) Second C5 -C7 Epidural with Catheterization is not medically necessary and appropriate.

H-Wave Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Stimulation, H-Wave Stimulation Page(s): 117.

Decision rationale: The California Medical Treatment Utilization Schedule states that an H-wave stimulation unit is not recommended as an isolated intervention, but a 1 month home based trial of H-wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation if used as an adjunct to a program of evidence based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation (TENS). The documents submitted for review did not contain any reports of physical therapy or the use of a TENS unit. The request did not indicate if the H-wave was rental or for purchase and it did not indicate the frequency of usage. Therefore, the request for H-Wave Unit is not medically necessary and appropriate.