

<b>Case Number:</b>	CM14-0113047		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	01/06/2014
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 Anesthesiology, has a subspecialty in Pain 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 55 year old male whose date of injury is 01/06/2014. On this date the injured worker was carrying a door when he stepped in a hole and felt pain in both shoulders and his neck. The injured worker has been authorized for 24 physical therapy visits to date. Diagnoses are cervicalgia, degenerative cervical intervertebral disc, brachial neuritis/radiculitis, and myofascial pain. Treatment to date also includes trigger point injections, Toradol injection and medication management. Office visit note dated 06/24/14 indicates that the injured worker complains of posterior neck pain, bilateral shoulder pain, bilateral hand pain and bilateral hand tingling. On physical examination there is mild tenderness over the neck and shoulder girdle. There is restricted movement in all directions. There is hypoesthesia to pinprick over C6 and C7 bilaterally. Deep tendon reflexes are normal. Tinel's is positive at the bilateral cubital tunnels.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical Traction Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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:** Based on the clinical information provided, the request for cervical traction unit is not recommended as medically necessary. The submitted records indicate that the injured worker was previously provided an inflatable traction unit, and he cannot tolerate this unit. There is no indication that the injured worker has undergone a successful trial of the door traction unit. There are no specific, time-limited treatment goals provided. Therefore, the request is not in accordance with the Official Disability Guidelines, and medical necessity is not established.

**Pain Psychology Consult and Testing:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluation, page 100-101 Page(s): 100-101.

**Decision rationale:** Based on the clinical information provided, the request for pain psychology consult and testing is not recommended as medically necessary. The submitted records fail to establish that the injured worker presents with any significant psychosocial issues which have impeded his progress in treatment completed to date. There is no clear rationale provided to support the requested consult and testing. Therefore, the request is not in accordance with CAMTUS guidelines, and medical necessity is not established.

**Physical Therapy 2-3x's wk/6 Wks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation, pages 58-60 Page(s): 58-60.

**Decision rationale:** Based on the clinical information provided, the request for physical therapy 2-3 x wk/6 weeks is not recommended as medically necessary. The submitted records indicate that the injured worker has been authorized for 24 physical therapy visits to date. CAMTUS guidelines support up to 10-12 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. The injured worker has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.