

Case Number:	CM14-0030479		
Date Assigned:	06/20/2014	Date of Injury:	04/25/2007
Decision Date:	11/05/2014	UR Denial Date:	02/17/2014
Priority:	Standard	Application Received:	03/10/2014

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 Internal Medicine 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 43-year-old male who reported a work related injury on 04/25/2007. The injured worker's diagnoses consist of lumbago. The injured worker's past treatment included surgical intervention, medication management, and injections. Diagnostic studies consisted of an MRI of the lumbar spine on 07/23/1971. However, those results were not provided for review. The injured worker's surgical history consisted of a lumbar fusion and cervical spine injection on 06/16/2014, which provided improvement. Upon examination on 08/11/2014, the injured worker complained of constant pain in his right shoulder which he described as burning and stabbing. He rated his pain as a 7/10 on the VAS pain scale. He also complained of numbness and tingling in the right arm. In regard to his neck, the injured worker complained of constant pain in his neck, which he described as burning, tight, and aching. He rated his pain as a 7/10 on the VAS pain scale. He also complained of numbness and tingling in the left side of his neck. In regard to the injured worker's lower back pain, he complained of constant back pain in his bilateral left greater than right lower back, which he described as stabbing, burning, and cramping. He rated his pain as an 8/10 on the VAS pain scale. He also complained of numbness and tingling which radiated to his bilateral legs. He noted that this pain is worsening. In addition, the injured worker also complained of difficulty falling asleep due to pain, waking during the night due to pain, dizziness, headaches, symptoms of anxiety due to pain or loss of work, and symptoms of depression. He stated that his pain was aggravated by prolonged sitting, standing, walking, repetitive bending, repetitive neck bending, repetitive stooping, and repetitive kneeling. On examination, it was revealed that palpation to the shoulder revealed nonspecific tenderness in the right shoulder. Hawkins test is positive on the right shoulder, and the Neer's test and impingement maneuvers revealed pain on the right shoulder. Examination of the cervical spine revealed reflexes for the biceps were normal bilaterally. Reflexes for the triceps were also

normal bilaterally. It was noted that the injured worker had no loss of sensibility, abnormal sensation, or pain in the anterolateral shoulder and arm on the right corresponding to the C5 dermatome. The patient had no loss of sensibility, abnormal sensation, or pain in the anterolateral shoulder and arm on the left corresponding to the C5 dermatome. There was also no loss of sensibility, abnormal sensation, or pain in the lateral forearm, hand, and thumb on the right corresponding to the C6 dermatome. The injured worker was prescribed medications including Zanaflex for spasms and Ultram for pain. The treatment plan consisted of request for a copy of the pain management report, authorization for an orthopedic surgery consultation surgery to address the low back, and continued pain management consultation. The rationale for the request was not submitted for review. A Request for Authorization form was submitted for review on 08/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Epidural Steroid Injection (ESI) at the C5-C6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), criteria for the use of Epidural Steroid Injection (ESI)

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

Decision rationale: The request for a cervical epidural steroid injection (ESI) at the C5-C6 is not medically necessary. According to the California MTUS Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain. Furthermore, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. Within the documentation provided, upon physical examination of the cervical spine it was noted that the injured worker had no neurological deficits. Additionally, a MRI was not provided for review. As such, clinical finding and imaging did not coincide with cervical radiculopathy to warrant the medical necessity of an epidural steroid injection. Therefore, the request for a cervical epidural steroid injection (ESI) at the C5-C6 is not medically necessary.

Thermocool hot/ cold contrast therapy with compression for 60 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) for the neck and upper back Continuous-flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & upper back, continuous-flow cryotherapy

Decision rationale: The request for thermocool hot/cold constant therapy is not medically necessary. The Official Disability Guidelines state, continuous-flow cryotherapy not

recommended in the neck. As such, the request for Thermocool hot/ cold contrast therapy with compression for 60 days is not medically necessary.