

Case Number:	CM14-0032625		
Date Assigned:	04/21/2014	Date of Injury:	05/04/2009
Decision Date:	07/02/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/14/2014

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 Orthopaedic Surgery 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:

This 59-year-old female sustained a neck and bilateral shoulder injury on 5/4/09. The mechanism of injury is not documented. The 1/9/14 treating physician report documented subjective complaints of neck, upper back, and bilateral shoulder pain. Exam findings noted +2 cervicothoracic and bilateral shoulder tenderness and diminished light touch sensation over the left thumb, long finger, and small finger tips. The diagnosis was cervical spine disc bulge, thoracic spine disc bulges, failed right shoulder surgery, and left shoulder strain. The 1/10/14 physical therapy report indicated that the patient had completed 10 visits of a cervical spine and upper extremity program from 9/20/13 to 1/10/14. Cervical range of motion was unchanged over the course of treatment and remained moderately limited. Muscle weakness improved in the middle deltoid, anterior deltoid, infraspinatus and supraspinatus groups from 2-/5 to 3/5 over the course of treatment. Current motor testing noted symmetrical weakness over the upper extremities. The patient reported a 20% reduction in pain, improved sleeping patterns, and improved activities of daily living capacity with physical therapy intervention. Compliance to a home exercise program was documented. Additional physical therapy was recommended 2 to 3 times per week for 4 to 6 weeks. Under consideration is a request for a cervical epidural steroid injection, 6 additional physical therapy visits to the shoulders, and a Saunders cervical traction unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL ESI: 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 (ESIS) Page(s): 46.

Decision rationale: Under consideration is a request for cervical epidural steroid injection (ESI). The California MTUS guidelines recommend epidural steroid injections for the treatment of radicular pain. Guideline criteria include radiculopathy documented by physical exam and corroborated by imaging studies and/or electrodiagnostic testing, initially unresponsive to conservative treatment, and a maximum of two injections for diagnostic purposes. Guideline criteria have not been met. The subjective complaints and exam findings documented do not support a corroborated diagnosis of radiculopathy as neither Imaging and/or electrodiagnostic findings are documented. There is no evidence that the patient has been unresponsive to conservative treatment. Therefore, this request for a cervical epidural steroid injection (ESI) is not medically necessary.

SIX (6) PHYSICAL THERAPY VISITS ON THE BILATERAL SHOULDERS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

Decision rationale: Under consideration is a request for 6 physical therapy visits on the bilateral shoulders. The California MTUS guidelines recommend physical medicine therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines generally support a course of 8 to 10 visits. Guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. Guidelines criteria have not been met. The patient has completed 10 physical therapy visits, including instruction in a home exercise program. There is no compelling reason presented to support the medical necessity of additional supervised physical therapy over an independent home exercise program to achieve further functional restoration. Therefore, this request for 6 physical therapy visits for the bilateral shoulders is not medically necessary.

SAUNDERS PNEUMATIC TRACTION-CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Physical Medicine.

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, Traction.

Decision rationale: Under consideration is a request for a Saunders pneumatic cervical traction unit. The California MTUS guidelines are silent regarding cervical traction units for chronic injuries. The Official Disability Guidelines recommend home cervical traction units for patients with radicular symptoms, in conjunction with a home exercise program. Guidelines generally support a trial of passive modalities, such as traction, for 2 to 3 weeks to assess benefit. Guideline criteria have not been met. There is no clear documentation of a cervical radicular pain pattern. There is no indication that the patient received traction during the recent physical therapy treatment. If traction was provided, there is no documentation of objective benefit to support the medical necessity of continued home use. Therefore, this request for a Saunders pneumatic cervical traction unit is not medically necessary.