

Case Number:	CM15-0014067		
Date Assigned:	01/27/2015	Date of Injury:	03/31/2012
Decision Date:	04/09/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/02/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 34-year-old female, who sustained an industrial injury on March 31, 2012. She has reported chronic neck and right shoulder pain from a fall. The diagnoses have included neck pain, cervical spine stenosis and cervical disc displacement. Treatment to date has included diagnostic studies, surgery, physical therapy and medications. On December 1, 2014, the injured worker complained of neck pain, right shoulder pain and headaches. Physical examination revealed decreased range of motion of the cervical spine and right shoulder and weakness to the bilateral upper extremities secondary to pain. On November 25, 2014 Utilization Review non-certified cervical epidural steroid injection and purchase of a motorized cold therapy unit for the neck, noting the CA MTUS and Official Disability Guidelines. On December 2, 2014, the injured worker submitted an application for Independent Medical Review for review of cervical epidural steroid injection and purchase of a motorized cold therapy unit for the neck.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

Decision rationale: The most recent report provided is dated 12/01/14 and states that the patient presents with neck and right shoulder pain along with headaches s/p total disc arthroplasty C4-5. The current request is for CERVICAL EPIDURAL STEROID INJECTION. The RFA is not included; however, the 11/25/14 utilization review states it is dated 11/18/14. As of 06/19/14 the patient is working. MTUS pages 46 and 47 states that Epidural Steroid Injections are recommended as an option for the treatment of radicular pain with corroborative findings for radiculopathy. Criteria for use include, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." MTUS further states, "there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." The reports provided do not discuss this request. The 06/09/14 report states that pain radiates from the cervical spine to the shoulders, arms, hands and fingers with occasional numbness and tingling in the hands and fingers. Subsequent report do not document radicular symptoms and there are no findings of neurological deficits. The 08/17/14 report states the MRI cervical is non-diagnostic due the presence of artifact. The reports state a CT scan is to be ordered; however, it is not discussed or provided for review. The 06/03/14 AME does provide an impression of C4-5 disc pathology with associated stenosis. In this case, there is no recent evidence of radicular pain corroborated by imaging for this patient. Furthermore, the MTUS guidelines state that there is insufficient evidence to make any recommendation for ESI to treat cervical radicular pain. Also, the request as presented does not state the cervical levels to be treated. The request IS NOT medically necessary.

Purchase of a motorized cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Thermal Modalities. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck and upper back chapter, Continuous flow cryotherapy.

Decision rationale: The most recent report provided is dated 12/01/14 and states that the patient presents with neck and right shoulder pain along with headaches s/p total disc arthroplasty C4-5 and s/p right shoulder arthroscopy of unspecified dates. The current request is for PURCHASE OF A MOTORIZED COLD THERAPY UNIT. The RFA is not included; however, the 11/25/14 utilization review states it is dated 11/18/14. As of 06/19/14 the patient is working. ODG, Continuous flow cryotherapy, states, "Not recommended in the neck. Recommended as an option after shoulder surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." The intended use of this request is not discussed in the reports provided for review. The patient has neck and shoulder complaints. The requested unit is not

recommended for the neck and for the shoulder only postoperatively. There is no evidence of recent or planned shoulder surgery in the reports provided. Furthermore, use is generally up to 7 days and the request for purchase suggests longer use. The request IS NOT medically necessary.