Case Number:	CM15-0188617		
Date Assigned:	09/30/2015	**Date of Injury:**	08/20/2002
Decision Date:	12/08/2015	**UR Denial Date:**	09/22/2015
Priority:	Standard	**Application Received:**	09/24/2015

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: Washington, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 72 year old female sustained an industrial injury on 8-20-02. Documentation indicated that the injured worker was receiving treatment for internal derangement of bilateral knees, discogenic lumbar condition, discogenic cervical condition and bilateral carpal tunnel syndrome. Comorbid conditions include diabetes. Previous treatment included right total knee replacement, bilateral carpal tunnel release, left knee Hyalgan injections, epidural steroid injections, hot and cold wrap, back brace, soft and rigid knee braces, transcutaneous electrical nerve stimulator (TENS) unit and medications. Prior nerve conduction study of the upper extremities (date not given) showed carpal tunnel syndrome but no evidence of a cervical neuropathy. Cervical MRI (2006) showed extradural defects at C3-4, C5-4 and C5-6 which was associated with smoe amount of stenosis. In a progress note dated 5-28-15, the injured worker presented for evaluation of the neck, back, knees and both hands. The injured worker reported that she was minimizing chores around the house and getting help with chores. Her knee braces did not fit her knees but her right knee was doing much better following total knee replacement. Physical exam was remarkable for tenderness along the left knee with "weakness" to resisted function and 100 degrees flexion. The treatment plan included requesting authorization for Flexeril, Nalfon, neck traction with air bladder, electromyography and nerve conduction velocity test of bilateral lower extremities to evaluate for nerve impingement, a pain management consultation for treatment of neck and low back pain, a transcutaneous electrical nerve stimulator unit, five Hyalgan injections to the left knee and cervical spine x-rays. In a progress note dated 9-11-15, the injured worker complained of pain along the neck, head, low back, bilateral knees and pain radiating to the right shoulder. The injured worker reported injuring the area along the right trapezius

while swimming. The physician stated that the injured worker had been doing quite well until this time but needed a refill of medications to be functional. Physical exam was remarkable for right shoulder with clicking and popping when she made her arm go straight and backwards, tenderness to palpation along the neck, trapezius and rotator cuff tendon with 100 degrees abduction with discomfort. She received trigger point injections during the office visit. The treatment plan included requesting authorization for medications (Norco, Nalfon and AcipHex), cortisone injection to the right shoulder subacromial space, referral for pain management for the neck and low back, cervical traction with air bladder and bilateral upper extremity electromyography and nerve conduction velocity test. On 9-22-15, Utilization Review noncertified a request for cortisone injection to the right shoulder subacromial space, referral for pain management for the neck and low back, cervical traction with air bladder and bilateral upper extremity electromyography and nerve conduction velocity test.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cortisone injection to the subacromial space of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Shoulder Complaints 2004, Section(s): Initial Care, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic)/Steroid injections.

Decision rationale: Injections into joints or soft tissue are a common option in treatment of tendon and joint inflammation. When used to treat shoulder tendonitis and/or bursitis research has shown injection of steroids with or without anesthetics to be effective in the short-term at controlling pain. ACOEM guidelines and the Official Disability Guidelines (ODG) recommend up to three such injections and that the injections be coupled with physical therapy. When used for injection of peripheral nerve impingement local anesthesia with or without steroids has been shown to be effective. This patient has shoulder pain, however, there is no exam documented that documents shoulder tendonitis, bursitis or shoulder impingement. Furthermore, there is no documentation of a trial of more conservative, non-invasive therapies or documentation of an ongoing home exercise program or instructions/request for physical therapy coupled with the request for steroid injection. Considering all the above information, this request for injection of the shoulder does not meet guideline criteria. The request for this procedure is not medically necessary and has not been established.

Referral for pain management for neck and low back pain: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7: Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic): Office Visits.

Decision rationale: Decision on when to refer to a specialist is based on the ability of the provider to manage the patient's disease. It relates to the provider's comfort point with the medical situation and the provider's training to deal with that situation. In this case the provider has a patient with chronic neck and back pain. However, there is no description of the pain, documentation of the signs or symptoms of disease or documentation of any affect by prior or present treatments. This information should be documented to justify the reason for such a referral. In this case, referral to a pain specialist to manage the patient's chronic pain is not appropriate without cogent evidence of need. The request is not medically necessary and has not been established.

Cervical traction with air bladder: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Neck and Upper Back Complaints 2004, Section(s): Initial Care, Summary, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Spinal traction is a passive physical modality of therapy used to lessen or eliminate muscle spasms and/or to relieve pressure on spinal nerves. The MTUS notes that, in general, passive therapy may be effective in the first few weeks after an injury but has not been shown to be effective after the period of the initial injury. ACOEM guidelines do not recommend traction when treating cervical disease as there is inadequate research-based evidence to support this therapy. However, the Official Disability Guidelines (ODG) recommends use of cervical traction in patients with radicular symptoms when the therapy is used in conjunction with a home exercise program. This patient has chronic neck pain and cervical MRI imaging documenting cervical degenerative disease. However, there is no documentation of signs or symptoms of cervical radiculopathy and no description of an ongoing home exercise program. Considering all the above information, the request for this therapy is not medically necessary and has not been established.

EMG/Nerve conduction study of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: Electromyography (EMG) and Nerve Conduction Velocity (NCV) are diagnostic tests used to measure nerve and muscle function, and may be indicated when there is pain in the limbs, weakness from spinal nerve compression, or concern about some other neurologic injury or disorder. Specifically, EMG testing is used to evaluate and record the electrical activity produced by skeletal muscles and NCV testing is used to evaluate the ability of the body's motor and sensory nerves to conduct electrical impulses. These tests can identify subtle focal neurologic dysfunction in patients whose physical findings are equivocal and prolonged (over 4 weeks). The ACOEM guidelines also recommend their use to clarify nerve root dysfunction in cases of disk herniation prior to surgery or epidural injections. Criteria for their use are very specific. When spinal cord etiologies are being considered, sensory-evoked potentials (SEPs) would better help identify the cause. This patient has neck symptoms present for over 4 weeks, but is not pending surgery or epidural steroid injection. Signs and symptoms suggesting axial nerve impingement are not documented and prior nerve conduction tests did not reveal a radicular nature to the patient's symptomatology. Given all the above information there is no indication for these tests at this time. The request is not medically necessary and has not been established.