

<b>Case Number:</b>	CM15-0202412		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	12/17/2001
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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: New York, California  
 Certification(s)/Specialty: Emergency 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:

The injured worker is a female who sustained an industrial injury on December 17, 2001. The worker is currently being treated for the following diagnoses: discogenic cervical condition; brachial plexus neuritis left upper extremity; left rotator cuff tear; discogenic lumbar condition; an element of depression, sleep disorder, and GERD. Subjective report on September 30, 2015 includes shooting back pain down to the left knee; depressed; sleep difficulty, gastroesophageal reflux; On June 02, 2015, the IW reported she was still working as tolerated although "in pain," climbing stairs hurts her knees, persistent; "prefers to take topical medications." Objective findings on September 30, 2015 included tenderness noted along the rotator cuff with findings of impingement; weakness to resisted function is noted: tenderness along the facet of the cervical spine and motion is satisfactory. The IW has had an MRI of the cervical spine. Prescribed medications in April and June included Voltaren gel and Lidoderm patches. Other treatments have included activity modification and TENS unit. On September 30, 2015 the IW received an initial Cortisone injection left shoulder; pending authorization: brace, hot and cold wrap, TENS unit with four leads, neck traction with air bladder, Celebrex, Aciphex, Tramadol ER, Flexeril, Lunesta, Effexor and 12 session of chiropractic care. On September 30, 2015 a request was made for cervical traction with air bladder, cervical pillow, 12 sessions of chiropractic care, hot and cold wrap, and Flexeril that were noncertified by Utilization review on October 08, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical traction with air bladder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation ODG-TWC.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Physical Examination, Initial Care, Activity Alteration. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head and Upper back chapter: Traction (mechanical).

**Decision rationale:** According to CA MTUS, there is "no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction..." ODG guidelines state, "Recommend home cervical patient controlled traction (using a seated over-the-door device or a supine device, which may be preferred due to greater forces), for patients with radicular symptoms, in conjunction with a home exercise program." The documentation does not support the IW has complaints of radicular symptoms or EMG studies to support the presence of such conditions. There is no documented home exercise program. Without this documentation and the poor evidence to support its use, the request for a cervical traction device is not medically necessary.

**Chiropractic 12 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** CA MTUS chronic pain guidelines for manual therapy and manipulation are used in support of this decision. It is unclear if the IW has previously had chiropractic care. It is therefore assumed this request is for first time chiropractor evaluation and treatment. According to referenced guidelines, manual therapies are recommended for musculoskeletal conditions. It is unclear what body part the chiropractor care is intended to treat. Nonetheless, guidelines recommend a trial of 6 visits over 2 weeks with evidence of functional improvements. The request for 12 visits exceeds this recommendation. The request for 12-chiropractic treatment is not within the guidelines and is not medically necessary.

**Cervical Pillow:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation ODG-TWC.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head and Upper Neck: pillow.

**Decision rationale:** CAMTUS is silent regarding this topic. According to the ODG reference, cervical pillow are "recommend use of a neck support pillow while sleeping, in conjunction with daily exercise. This RCT concluded that subjects with chronic neck pain should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep; either strategy alone did not give the desired clinical benefit." The documentation does not support the IW engages in a daily exercise program or any ongoing physical medicine treatments. Without the support of the documentation or adherence to the guidelines, request for a cervical neck pillow is determined not medically necessary.

**Hot and Cold Wrap:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC.

**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: cold/heat packs.

**Decision rationale:** CA MTUS is silent regarding this topic. ODG recommends heat packs in the setting of acute pain. The documentation supports the IW has ongoing, chronic pain conditions. There is no documentation to support the IW has ever used heat as a modality to treat her injuries, either at home or under the care of a therapist. It is unclear why a special hot/cold pack device is being requested rather than the use of simple ice and heating pad. Without the support of the documentation or clarity of the requested need, the request for heat and cold wrap is determined not medically necessary.

**Flexeril 7.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

**Decision rationale:** According to CA MTUS, cyclobenzaprine is recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. The IW has been receiving this prescription for a minimum of 6 months according to submitted records. This greatly exceeds the recommended timeframe of treatment. In addition, the request does not include dosing frequency or duration. The IW's response to this medication is not discussed in the documentation. The request is not medically necessary.