

<b>Case Number:</b>	CM15-0025846		
<b>Date Assigned:</b>	02/18/2015	<b>Date of Injury:</b>	01/03/2009
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	02/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/11/2015

### 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: 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 46 year old female, who sustained an industrial injury on January 3, 2009. The diagnoses have included bilateral carpal tunnel syndrome, cervical disc with bilateral upper extremity neuralgia, right shoulder impingement, depression and sleep disorder. A progress note dated January 6, 2015 provided the injured worker complains of wrist and hand pain. Physical exam notes painful range of motion (ROM) in wrists and tenderness on palpation. On February 5, 2015 utilization review non-certified a request for cervical epidural injection, use of cold therapy unit and interferential unit and modified a request for coordination of acupuncture and physical therapy. The Official Disability Guidelines (ODG) were utilized in the determination. Application for independent medical review (IMR) is dated February 11, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical Epidural Injection:** Upheld

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

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

**Decision rationale:** The patient presents with complaints of neck pain. The request is for CERVICAL EPIDURAL INJECTION. The RFA is not provided. Objective findings reported in the progress report dated 11/25/14 included decreased sensory C6-C7 right, positive cervical MRI revealing 3-4mm disc at C5-C6 with annular tear cervical, range of motion 45 at flexion and 20 at extension. NCV and EMG bilateral upper extremities were within normal limits. Patient's diagnosis included cervical disc with bilateral upper extremity neuralgia. Per progress report dated 12/05/14, the patient is status post cervical epidural injections X2 last year. It is not clear whether or not the patient is currently working. MTUS has the following regarding ESIs, under its chronic pain section: Page 46, 47: "Criteria for the use of Epidural steroid injections: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. MTUS states on p46, "there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." In this case, the patient has decreased sensory at C6-C7, but radiculopathy has not been demonstrated via MRI and physical examination. MRI only shows 3-4mm disc at C5-C6 with annular tear cervical without a potential nerve root lesion. ESI would not be indicated without a clear diagnosis of radiculopathy. Furthermore, the patient is status post cervical epidural injections X2 last year. Repeat injections should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. Review of the progress reports provided did not show a documentation of 50% reduction of pain lasting 6-8 weeks or functional improvement/medication reduction following the previous injections. The request is not in accordance with the guidelines. The request IS NOT medically necessary.

**Coordination of Acupuncture and Physical Therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
9792.24.1. Acupuncture Medical Treatment Guidelines Physical medicine Page(s): 13, 98-99.

**Decision rationale:** The patient presents with complaints of neck and bilateral wrist pain. The request is for COORDINATION OF ACUPUNCTURE AND PHYSICAL THERAPY. The RFA is not provided. Objective findings reported in the progress report dated 11/25/14 included decreased sensory C6-C7 right, positive cervical MRI revealing 3-4mm disc at C5-C6 with annular tear cervical, range of motion 45 at flexion and 20 at extension. NCV and EMG

bilateral upper extremities were within normal limits. Patient's diagnosis included bilateral carpal tunnel syndrome, cervical disc with bilateral upper extremity neuralgia, right shoulder impingement, depression and sleep disorder. It is not clear whether or not the patient is currently working. For acupuncture, the MTUS Guidelines page 8 recommends acupuncture for pain, suffering, and for restoration of function. Recommended frequency and duration is 3 to 6 treatments for trial, and with functional improvement, 1 to 2 per month. For additional treatment, MTUS Guidelines require functional improvement as defined by Labor Code 9792.20(e), a significant improvement in ADLs, or change in work status and reduced dependence on medical treatments. MTUS pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits over 4 weeks are recommended." Review of the medical records does not show a history of physical therapy or acupuncture treatments. Assuming that the patient has not received PT and acupuncture therapies in the past and given that the patient continues to experience chronic pain, the requested physical therapy and acupuncture treatment may be reasonable; however, the treater has failed to indicate the affected body parts, the number, and duration of these sessions. Due to insufficient information available for assessment, the request cannot be considered to be in accordance with the guidelines. Therefore, the request IS NOT medically necessary.

**Use of Cold Therapy unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder Chapter; Neck Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter under continuous flow cryotherapy.

**Decision rationale:** The patient presents with complaints of neck and bilateral wrist pain. The request is for USE OF COLD THERAPY UNIT. The RFA is not provided. Objective findings reported in the progress report dated 11/25/14 included decreased sensory C6-C7 right, positive cervical MRI revealing 3-4mm disc at C5-C6 with annular tear cervical, range of motion 45 at flexion and 20 at extension. NCV and EMG bilateral upper extremities were within normal limits. Patient's diagnosis included bilateral carpal tunnel syndrome, cervical disc with bilateral upper extremity neuralgia, right shoulder impingement, depression and sleep disorder. It is not clear whether or not the patient is currently working. The MTUS and ACOEM Guidelines do not discuss water therapy units. ODG Guidelines Pain Chapter under continuous flow cryotherapy states, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In a postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." The treater does not provide a rationale for the request and has not indicated how the unit will be used. ODG Guidelines do not support this type of device other

than for postoperative recovery. In this case, the patient is not in a postoperative setting. The request IS NOT medically necessary.

**Interferential Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder Chapter; Pain Chapter; Neck Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

**Decision rationale:** The patient presents with complaints of neck and bilateral wrist pain. The request is for INTERFERENTIAL UNIT. The RFA is not provided. Objective findings reported in the progress report dated 11/25/14 included decreased sensory C6-C7 right, positive cervical MRI revealing 3-4mm disc at C5-C6 with annular tear cervical, range of motion 45 at flexion and 20 at extension. NCV and EMG bilateral upper extremities were within normal limits. Patient's diagnosis included bilateral carpal tunnel syndrome, cervical disc with bilateral upper extremity neuralgia, right shoulder impingement, depression and sleep disorder. Per progress report dated 12/05/14, the patient is status post cervical epidural injections X2 last year. It is not clear whether or not the patient is currently working. Regarding Interferential Current Stimulation, the MTUS guidelines, pages 118 - 120, states: "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone.? These devices are recommended in cases where 1. Pain is ineffectively controlled due to diminished effectiveness of medications; or 2. Pain is ineffectively controlled with medications due to side effects; or 3. History of substance abuse; or 4. Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or 5. Unresponsive to conservative measures."The treater does not provide a rationale for the request and has not indicated how the unit will be used. A one month trial of the unit may be appropriate if pain is not effectively controlled due to diminished effectiveness or side effects of medication; history of substance abuse, significant pain due to postoperative conditions; or when the patient is unresponsive to conservative measures. In this case, review of the medical records does not show a history of physical therapy or acupuncture treatments or any other failed conservative treatments. Per the UR letter dated 02/05/15, the patient has been authorized to receive 5 sessions of PT for neck and shoulder and 5 sessions of acupuncture treatments. Currently, the relevance of the use of this unit is pending completion of the conservative treatments currently being authorized and their subsequent evaluation of responsiveness. Therefore, the request for interferential unit IS NOT medically necessary.