

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0081799 |                              |            |
| <b>Date Assigned:</b> | 05/04/2015   | <b>Date of Injury:</b>       | 12/06/2010 |
| <b>Decision Date:</b> | 06/09/2015   | <b>UR Denial Date:</b>       | 04/07/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/28/2015 |

### 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, Hawaii  
 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 57-year-old male who sustained an industrial injury on 12/6/10. The injured worker reported symptoms in the back and left shoulder. The injured worker was diagnosed as having lumbosacral spine musculoligamentous strain/sprain, lumbar spine multiple disc protrusions, left shoulder strain/sprain, left shoulder tendinitis, left shoulder impingement, left shoulder rotator cuff tear, and acromioclavicular joint osteoarthritis/bursitis. Treatments to date have included chiropractic treatments, activity modification, physical therapy, and oral pain medication. Currently, the injured worker complains of lower back and left shoulder pain. The plan of care was for diagnostics and a cervical traction collar.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical traction collar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck Chapter, Traction (Mechanical).

**Decision rationale:** The patient has continued reports of neck, low back and left shoulder pain along with intermittent radiation into the upper and lower extremity. The current request is for Cervical Traction Collar. While ACOEM guidelines do not support traction, ODG guidelines have a more thorough discussion regarding chronic neck radiculopathy and traction. ODG recommends "home cervical patient controlled traction (using a seated over-the-door device or a supine device), for patients with radicular symptoms, in conjunction with a home exercise program. ODG does not recommend institutionally based powered traction devices. In this case, the request is for a cervical traction collar. There is nothing in the medical records to indicate that the patient has attempted a trial of in office traction demonstrating positive short or long-term benefit. Furthermore, electrodiagnostic studies were negative for electrical evidence of cervical radiculopathy or plexopathy at the C5-T1 levels. The request is not medically necessary.

**MRI brain:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Head Chapter, MRI.

**Decision rationale:** The patient has continued reports of neck, low back and left shoulder pain along with intermittent radiation into the upper and lower extremity. The current request is for MRI of the Brain. The MTUS is quiet on this matter. The ODG indicates that Magnetic Resonance Imaging (MRI) is a well-established brain imaging study. MRI scans are useful to assess transient or permanent changes, to determine the etiology of subsequent clinical problems, and to plan treatment. MRI is more sensitive than CT for detecting traumatic cerebral injury. Indications for MRI include: Determining neurological deficits not explained by CT, evaluating prolonged interval of disturbed consciousness, and to define evidence of acute changes superimposed on previous trauma or disease. In this case, an attending physician report dated 2/3/15 indicates no electrical evidence of a cervical radiculopathy or plexopathy affecting the C5-T1 lower motor nerve fibers of the bilateral upper extremities or the cervical paraspinals. The current subjective complaints and objective findings are consistent with cervical facet or cervical discogenic referred pain. There is nothing in the records to establish medical necessity for an MRI of the brain based upon the medical guideline criteria. The request is not medically necessary.