

Case Number:	CM14-0216304		
Date Assigned:	01/06/2015	Date of Injury:	10/17/2002
Decision Date:	02/23/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	12/24/2014

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: Ohio, North Carolina, Virginia
Certification(s)/Specialty: Family Practice

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 50 year old female with a date of injury of 10/17/2002, She complains of non-radiating neck pain, mid-back and left shoulder pain. The physical examination reveals tenderness of the spinous processes from C3 through C7 and trigger point tenderness of the paravertebral muscles of the cervical and thoracic spine. Light touch sensation is noted to be intact throughout however the submitted medical record does not contain a more detailed neurologic exam. The diagnoses include myalgia/myositis, thoracic or thoracolumbar disc degeneration, and sprain/strain of the neck and thoracic regions. She has completed 8 sessions of acupuncture which was only temporarily helpful. She has had physical therapy sessions which were said to provide 60% relief, The medications include anti-inflammatories, hydrocodone, tramadol, and topical analgesics. At issue are requests for an MRI of the cervical spine and an interferential unit. Each was non-certified citing MTUS and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the cervical spine (without contrast): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178,Chronic Pain Treatment Guidelines. Decision based on

Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) updated 11/18/2014

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neck and Upper Back

Decision rationale: Per the Official Disability Guidelines, the indications for MRI of the cervical spine are as follows:- Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present- Neck pain with radiculopathy if severe or progressive neurologic deficit- Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present- Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present- Chronic neck pain, radiographs show bone or disc margin destruction- Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"- Known cervical spine trauma: equivocal or positive plain films with neurological deficit- Upper back/thoracic spine trauma with neurological deficit
In this instance, the submitted records do not indicate the injured worker had complained of neurologic symptoms. The submitted record did not reveal neurologic deficits. There is no reference to radiographs within the record. Consequently, with reference to the submitted medical record and in accord with the referenced guidelines, MRI of the cervical spine is not medically necessary.

Interspec IF II (interferential unit): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines transcutaneous electrical stimulation Page(s): 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back (Acute & Chronic) updated 11/18/2014

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy.

Decision rationale: While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine:- Pain is ineffectively controlled due to diminished effectiveness of medications; or- Pain is ineffectively controlled with medications due to side effects; or- History of substance abuse; or- Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or- Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those guideline criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. An IF unit should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. The request is not medically necessary.

