Case Number:	CM15-0014405		
Date Assigned:	02/02/2015	**Date of Injury:**	08/20/2008
Decision Date:	03/25/2015	**UR Denial Date:**	01/15/2015
Priority:	Standard	**Application Received:**	01/26/2015

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 Jersey, Michigan, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 49 year old female, who sustained an industrial injury on August 20, 2008. She has reported a repetitive stress injury to the neck and upper extremities. The diagnoses have included cervical post laminectomy syndrome and carpal tunnel syndrome. Treatment to date has included physical therapy, pain medication, anti-inflammatory medication, anterior cervical discectomy and fusion, bilateral carpal tunnel release surgery and home exercise program. Currently, the injured worker complains of worsening neck pain and reports that she feels her neck is locked up. She rated her pain an 8 on a 10-point scale. On examination, she has decreased sensation in the bilateral median nerve distribution and tenderness throughout the cervical paraspinal musculature. Her cervical flexion and extension is limited to five degrees and bilateral rotation to 45 degrees with negative Spurling's maneuver. On January 15, 2015 Utilization Review non-certified a request for of additional eight physical therapy to the neck and upper extremities and an inversion table, noting that there was no documentation to support additional therapy sessions and a home exercise program was more appropriate and nothing that there have been no trials of any use of an inversion table that have provided significant or prolonged functional and pain improvement. The California Medical Treatment Utilization Schedule and the Official Disability Guidelines were cited. On January 26, 2015, the injured worker submitted an application for IMR for review of additional eight physical therapy to the neck and upper extremities and an inversion table.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional 8 physical therapy to the neck and upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: According to MTUS guidelines, Physical Medicine is "Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006)Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)".There is no documentation of the efficacy and outcome of previous physical therapy sessions. The patient underwent 8 sessions of physical therapy without clear documentation of efficacy. There is no recent objective findings that support musculoskeletal dysfunction requiring additional physical therapy. There is no documentation that the patient cannot perform home exercise. Therefore, Additional physical therapy, 8 sessions is not medically necessary.

Inversion table: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Traction (mechanical) http://www.odg-twc.com/index.html

Decision rationale: According to ODG guidelines, inversion table (Traction (mechanical). " 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. Not recommend institutionally based powered traction devices. Several studies have demonstrated that home cervical traction can provide symptomatic relief in over 80% of patients with mild to moderately severe (Grade 3) cervical spinal syndromes with radiculopathy. (Aetna, 2004) (Olivero, 2002) (Joghataei, 2004) (Shakoor, 2002) Patients receiving intermittent traction performed significantly better than those assigned to the no traction group in terms of pain, forward flexion, right rotation and left rotation. (Zylbergold, 1985) Other studies have concluded there is limited documentation of efficacy of cervical traction beyond short-term pain reduction. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. (Kjellman, 1999) (Gross-Cochrane, 2002) (Aker, 1999) (Bigos, 1999) (Browder, 2004) This Cochrane review found no evidence from RCTs with a low potential for bias that clearly supports or refutes the use of either continuous or intermittent traction for neck disorders. (Graham, 2008) The Pronex and Saunders home cervical traction devices are approved for marketing as a form of traction. Although the cost for Pronex or Saunders is more than an over-the-door unit, they are easier to use and less likely to cause aggravation to the TMJ. Therefore, these devices may be an option for home cervical traction. (Washington, 2002) For decades, cervical traction has been applied widely for pain relief of neck muscle spasm or nerve root compression. It is a technique in which a force is applied to a part of the body to reduce paravertebral muscle spasms by stretching soft tissues, and in certain circumstances separating facet joint surfaces or bony structures. Cervical traction is administered by various techniques ranging from supine mechanical motorized cervical traction to seated cervical traction using an over-the-door pulley support with attached weights. Duration of cervical traction can range from a few minutes to 30 min, once or twice weekly to several times per day. In general, over-the-door traction at home is limited to providing less than 20 pounds of traction. See also Manual traction. Recent research: Recent studies have documented good results using traction to treat cervical radiculopathy with traction forces from 20 to 55 lbs (more than an over-the-door unit can provide). Cervical traction should be combined with exercise techniques to treat patients with neck pain and radiculopathy. (Raney, 2009) In comparing the intervertebral separation obtained with supine pneumatic traction (using the Saunders Cervical Traction Device) to seated traction (using an over-the-door home traction device), the supine device caused significantly greater separation vs. over-the-door traction. (Fater, 2008) In reviewing the current published evidence, this guideline concluded that cervical traction is recommended to treat cervical radiculopathy using greater than 20 lbs intermittent force. (Childs, 2008)". There is no clear documentation of cervical radiculopathy and there is no rational behind the use of more physical therapy session including the use of inversion table . There no documentation that the patient cannot perform home exercise. Therefore, the request is not medically necessary. There is no clear documentation of cervical radiculopathy and there is no rational behind the use of more physical therapy session including the use of inversion table . There no documentation that the patient cannot perform home exercise. Therefore, the request is not medically necessary.