

Case Number:	CM15-0123123		
Date Assigned:	07/07/2015	Date of Injury:	07/16/2009
Decision Date:	08/26/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/25/2015

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 60 year old female, who sustained an industrial injury on 7/16/09. The diagnoses have included chronic post traumatic neck with progressive exacerbation, cervical spondylosis, cervical radiculopathy, cervical stenosis, grade I spondylolisthesis, carpal tunnel syndrome, and rotator cuff syndrome. Treatment to date has included medications, activity modifications, off work, diagnostics, splinting, bracing, other modalities and physical therapy. Currently, as per the physician progress note dated 5/19/15, the injured worker complains of persistent neck pain with frequent occipital pain and left neck pain. She also notes arm pain and she states that it is worsening. She also has pain with range of motion of the neck. She has persistent periscapular pain and notes that her walking and balance are impaired. She states that the neck and arm pain increase upon awakening in the morning and are worsening. The physical exam reveals that the neck has limited range of motion, tenderness, spasm and she is uncomfortable as she moves with maneuvers. She has lack of range of motion with flexion and extension. There is diffuse diminution to pin over the C6 and C7 distribution and she is weak in the right arm. The diagnostic testing that was performed included x-ray of the cervical spine that reveals degenerative changes and retrolisthesis and anterolisthesis and Magnetic Resonance Imaging (MRI) of the cervical spine, which reveals multi-level degenerative changes with spinal canal narrowing. There is also a report of an electromyography (EMG)/ nerve conduction velocity studies (NCV) of the upper extremities. The injured worker is working full time. The physician requested treatments included Aspen cervical collar #1, Head halter traction #1, Follow up appointment on 08/27/2015 and X-ray of cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aspen cervical collar #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175.

Decision rationale: The patient presents with pain in neck, forearm, and bilateral hands. The request is for aspen cervical collar #1. The request for authorization is not provided. MRI of the cervical spine, 11/07/14, shows multilevel degenerative changes throughout the cervical spine with moderate spinal canal narrowing at C4-C5 and C5-C6. X-rays of the cervical spine, 09/25/14, showed minimal retrolisthesis of C3 on C4, anterolisthesis of C4 on C5, and anterolisthesis of C5 on C6; degenerative changes at C5-6 and C6-7. EMG/NCS of both upper extremities, 11/10/14, shows study is abnormal; there is electrophysiological evidence of moderate delay involving the median nerve at the wrist in the carpal tunnel bilaterally consistent with the clinical impression of bilateral carpal tunnel syndrome; needle EMG exam of the muscles tested in both upper extremities and cervical paraspinals tested on the right side did not show any electrophysiological evidence of acute and/or ongoing denervation. Physical examination of the neck reveals limitation in range of motion, 1+ tenderness, 1+ spasm. Sensory exam reveals diffuse diminution to pin over the C6 and C7 distribution. Motor exam reveals she is diffusely weak in her right arm. Patient's medications include Lisinopril, Glyburide-Metformin, Thyroid medication and Cholesterol medication. Per progress report dated 06/11/15, the patient is modified duty. The ACOEM chapter 8 page 175 states, "Cervical collars: Initial care, other miscellaneous therapies have been evaluated and found to be ineffective or minimally effective. For example, cervical collars have not been shown to have any lasting benefit, except for comfort in the first few days of clinical course in severe cases; in fact, weakness may result from prolonged use and will contribute to debilitation. Immobilization using collars in prolonged periods of rest are generally less effective than having patients maintain their usual, 'pre-injury' activities." Regarding cervical collars, the ODG Guidelines under its neck and upper back chapters states, "Maybe appropriate where post-operative and fracture indications exist." Per progress report dated 05/19/15, treater's reason for the request is "when she is up and active." The patient complains of persistent neck pain with frequent occipital pain and left neck pain. Physical examination of the neck reveals limitation in range of motion. However, ACOEM guidelines do not support cervical collars and ODG states it may be appropriate for post-operative use or when there is a fracture. In this case, the patient is not in a post-operative state and there is no concern for fracture. Therefore, the request is not medically necessary.

Head halter traction #1: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The patient presents with pain in neck, forearm, and bilateral hands. The request is for head halter traction #1. The request for authorization is not provided. MRI of the cervical spine, 11/07/14, shows multilevel degenerative changes throughout the cervical spine with moderate spinal canal narrowing at C4-C5 and C5-C6. X-rays of the cervical spine, 09/25/14, showed minimal retrolisthesis of C3 on C4, anterolisthesis of C4 on C5, and anterolisthesis of C5 on C6; degenerative changes at C5-6 and C6-7. EMG/NCS of both upper extremities, 11/10/14, shows study is abnormal; there is electrophysiological evidence of moderate delay involving the median nerve at the wrist in the carpal tunnel bilaterally consistent with the clinical impression of bilateral carpal tunnel syndrome; needle EMG exam of the muscles tested in both upper extremities and cervical paraspinals tested on the right side did not show any electrophysiological evidence of acute and/or ongoing denervation. Physical examination of the neck reveals limitation in range of motion, 1+ tenderness, 1+ spasm. Sensory exam reveals diffuse diminution to pin over the C6 and C7 distribution. Motor exam reveals she is diffusely weak in her right arm. Patient's medications include Lisinopril, Glyburide-Metformin, Thyroid medication and Cholesterol medication. Per progress report dated 06/11/15, the patient is modified duty. MTUS does not provide guidance on home traction devices, so ACOEM was referenced. ACOEM, Chapter: 12, page 300, does not recommend traction for the cervical spine, due to a lack of evidence either in support or opposition of traction. ODG, Chapter 'Neck and Upper Back (Acute & Chronic)' and topic 'Traction (mechanical)' does provide evidenced based support of patient controlled home traction devices "using a seated over-the-door device or a supine device for patients with radicular symptoms; when used in conjunction with a home exercise program." Per progress report dated 05/19/15, treater's reason for the request is "She will use the head halter traction at six pounds twice a day five minutes at a time." The patient complains of persistent neck pain with frequent occipital pain and left neck pain. Physical examination of the neck reveals limitation in range of motion. ACOEM guidelines, however, do not support the use of cervical traction units while ODG guidelines support their use only for radicular symptoms in conjunction with a home exercise program. In this case, although the patient has a diagnosis of bilateral cervical radiculopathy right greater than left, a clear diagnosis of radiculopathy is not apparent based on MRI findings. Nevertheless, given the patient's significant radicular symptoms, a trial of home traction unit may be supported per ODG guidelines. Therefore, the request is medically necessary.

Follow up appointment on 08/27/2015: Overturned

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 ACOEM Guidelines, Chapter 7, page 127.

Decision rationale: The patient presents with pain in neck, forearm, and bilateral hands. The request is for FOLLOW UP APPOINTMENT ON 08/27/2015. The request for authorization is not provided. MRI of the cervical spine, 11/07/14, shows multilevel degenerative changes throughout the cervical spine with moderate spinal canal narrowing at C4-C5 and C5-C6. X-rays of the cervical spine, 09/25/14, showed minimal retrolisthesis of C3 on C4, anterolisthesis of C4 on C5, and anterolisthesis of C5 on C6; degenerative changes at C5-6 and C6-7. EMG/NCS of both upper extremities, 11/10/14, shows study is abnormal; there is electrophysiological evidence of moderate delay involving the median nerve at the wrist in the carpal tunnel bilaterally consistent with the clinical impression of bilateral carpal tunnel syndrome; needle EMG exam of the muscles tested in both upper extremities and cervical paraspinals tested on the right side did not show any electrophysiological evidence of acute and/or ongoing denervation. Physical examination of the neck reveals limitation in range of motion, 1+ tenderness, 1+ spasm. Sensory exam reveals diffuse diminution to pin over the C6 and C7 distribution. Motor exam reveals she is diffusely weak in her right arm. Patient's medications include Lisinopril, Glyburide-Metformin, Thyroid medication and Cholesterol medication. Per progress report dated 06/11/15, the patient is modified duty. ACOEM Practice Guidelines, 2nd Edition (2004), page 127 has the following: The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. In this case, the patient had a neurosurgical consultation with [REDACTED] on 05/19/15. In this case, it appears the treater is requesting a follow up visit to further evaluate the treatment plan. Therefore, the request is medically necessary.

X-ray of cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, under Radiography.

Decision rationale: The patient presents with pain in neck, forearm, and bilateral hands. The request is for X-RAY OF CERVICAL SPINE. The request for authorization is not provided. MRI of the cervical spine, 11/07/14, shows multilevel degenerative changes throughout the cervical spine with moderate spinal canal narrowing at C4-C5 and C5-C6. X-rays of the cervical spine, 09/25/14, showed minimal retrolisthesis of C3 on C4, anterolisthesis of C4 on C5, and anterolisthesis of C5 on C6; degenerative changes at C5-6 and C6-7. EMG/NCS of both upper extremities, 11/10/14, shows study is abnormal; there is electrophysiological evidence of moderate delay involving the median nerve at the wrist in the carpal tunnel bilaterally consistent with the clinical impression of bilateral carpal tunnel syndrome; needle EMG exam of the muscles tested in both upper extremities and cervical paraspinals tested on the right side did not show any electrophysiological evidence of acute and/or ongoing denervation. Physical examination of the neck reveals limitation in range of motion, 1+ tenderness, 1+ spasm. Sensory exam reveals diffuse diminution to pin over the C6 and C7 distribution. Motor exam reveals she is diffusely weak in her right arm. Patient's medications include Lisinopril, Glyburide-

Metformin, Thyroid medication and Cholesterol medication. Per progress report dated 06/11/15, the patient is modified duty. ACOEM guidelines on special studies for C-spine Chapter 8 (p177,178) states: "X-rays: Initial studies may be warranted only when potentially serious underlying conditions are suspected like fracture or neurologic deficit, cancer, infection or tumor. (Bigos, 1999) (Colorado, 2001); Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure." ODG Neck and Upper Back Chapter, under Radiography has the following: Not recommended except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography. There is little evidence that diagnostic procedures for neck pain without severe trauma or radicular symptoms have validity and utility. Per progress report dated 05/19/15, treater's reason for the request is "to compare to her prior studies to evaluate for any worsening of her spondylolisthesis." Review of provided medical records show a prior X-ray of the cervical spine was performed on 09/25/14. However, treater does not discuss any new injury or emergence of a red flag, nor has the patient had surgery. The request does not meet guidelines indication. Therefore, the request is not medically necessary.