

Case Number:	CM15-0175792		
Date Assigned:	09/17/2015	Date of Injury:	07/01/2012
Decision Date:	10/23/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/08/2015

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 July 1, 2012, incurring upper back, and shoulder and neck injuries. Cervical Magnetic Resonance Imaging revealed disc disease, stenosis and Kyphosis. She was diagnosed with a sprained cervical spine, cervical degenerative disc disease, cervical spondylosis, cervical radiculitis and left strained shoulder. Treatment included anti-inflammatory drugs, steroids, pain medications, and activity restrictions and modifications. Currently, the injured worker complained of left sided neck pain with tingling and paresthesia in the left hand. She noted increased stiffness of her neck and muscle tightness of the left upper shoulder and neck. Her pain was relieved by rest, heat and massage. She was further diagnosed with left carpal tunnel syndrome, neuropathy of the left wrist and cervical spine strain with a left shoulder strain interfering with her activities of daily living such as self-care, grooming, cooking and household chores. She had difficulty sleeping due to increased muscle spasms radiating throughout the left upper extremity down into her thumb. The cervical pain was aggravated with prolonged driving, positioning, twisting, leaning, pulling, carrying and lifting. The treatment plan that was requested for authorization on August 24, 2015, included left cervical epidural steroid injection, cervical traction unit and interferential unit, 30 day trial for home use. On August 21, 2015, a request for a left cervical epidural steroid injection and a cervical traction unit and interferential unit was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left C4-C5 and left C5-C6 transfacet epidural steroid injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The patient presents with pain in the cervical spine radiating to the left shoulder. The request is for Left C4-C5 and left C5-C6 transfacet epidural steroid injection. Physical examination to the cervical spine on 06/23/15 revealed tenderness to palpation over the paravertebral musculature extending to the left trapezius muscle with spasm. Range of motion was decreased in all planes. Per 07/15/15 progress report, patient's diagnosis includes radiculopathy of cervical spine, mild impingement of left shoulder, and mild triggering of left thumb. Patient's work status is modified duties. MTUS Chronic Pain Medical Treatment Guidelines 2009, page 46, Epidural Steroid Injections (ESIs) section states: "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." In progress report dated 06/23/15, treater states that the patient has failed conservative treatment in the form of physical therapy, chiropractic manipulative therapy, medication, rest and a home exercise program of more than 6 weeks over the past 12 months and is requesting for a left C4-C5 and C5-C6 transfacet epidural steroid injection. Review of the medical records provided did not indicate a prior injection. The patient continues to suffer with neck pain that radiates to the left shoulder. MRI findings of 05/06/15 showed a 3-mm broad midline disc protrusion resulting in flattening of the thecal sac with a mild central canal narrowing at C3-C4, and at C4-C5, C5-C6 and C6-C7, there are 2-mm midline disc protrusions resulting in central canal narrowing. Given the patient's radicular pain and corroborated image findings, the request appears to be reasonable. Therefore, the request is medically necessary.

Cervical traction 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, Neck and Upper Back, Traction.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care.

Decision rationale: The patient presents with pain in the cervical spine radiating to the left shoulder. The request is for Cervical traction unit. Physical examination to the cervical spine on 06/23/15 revealed tenderness to palpation over the paravertebral musculature extending to the left trapezius muscle with spasm. Range of motion was decreased in all planes. Per 07/15/15 progress report, patient's diagnosis includes radiculopathy of cervical spine, mild impingement of left shoulder, and mild triggering of left thumb. Patient's work status is modified duties. MTUS is silent on home traction devices. Therefore ACOEM and ODG were referenced. ACOEM Guidelines, Neck and Upper Back Complaints, Chapter 8, page 173 on C-spine traction states, "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction. These palliative tools may be used on a trial basis but should be monitored closely. Furthermore, page 181 ACOEM lists "traction" under "Not Recommended" section for summary of recommendations and evidence table 8-8. ODG-TWC, Neck and Upper Back (Acute & Chronic) Chapter, under Traction (mechanical) states: "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)" The treater has not specifically addressed this request; no RFA was provided either. The patient presents with neck pain that radiates to the left shoulder and diagnosed with radiculopathy of the cervical spine. Given the patient's symptoms and diagnosis, a trial of a cervical traction device would be indicated per ODG, although it is not supported by ACOEM. However, the request does not specify the type of home traction unit. Mechanical or powered devices are not recommended per ODG. Given the lack of clarity as what type of traction device is being asked for, the request is not medically necessary.

IF unit; 30 day trial for home use: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The patient presents with pain in the cervical spine radiating to the left shoulder. The request is for IF unit, 30 day trial for home use. Physical examination to the cervical spine on 06/23/15 revealed tenderness to palpation over the paravertebral musculature extending to the left trapezius muscle with spasm. Range of motion was decreased in all planes. Per 07/15/15 progress report, patient's diagnosis includes radiculopathy of cervical spine, mild impingement of left shoulder, and mild triggering of left thumb. Patient's work status is modified duties. MTUS Chronic Pain Medical Treatment Guidelines 2009, Transcutaneous electrotherapy section, pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "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.). The treater has not specifically discussed this request and no RFA was provided either. The patient continues with neck pain that radiates to the left shoulder and diagnosed with radiculopathy of the cervical spine. In progress report dated 06/23/15, treater states that the patient has failed conservative treatment in the form of physical therapy, chiropractic manipulative therapy, medication, rest and a home exercise program of more than 6 weeks over the past 12 months. Review of the medical records provided did not indicate prior use of an IF unit. ODG Guidelines support the use/trial of an IF unit when conservative therapy has failed. Given the patient's continued pain and failed conservative therapy, a one month trial of an IF unit appears to be reasonable. Therefore, the Request is medically necessary.