

Case Number:	CM15-0095193		
Date Assigned:	05/21/2015	Date of Injury:	09/26/2012
Decision Date:	06/24/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/18/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 56-year-old female, who sustained an industrial injury on 9/26/2012. She reported stress and strain of employment. The injured worker was diagnosed as having neck pain with multilevel disc protrusion, paracervical muscle and left upper trapezius spasm, cervical spondylosis, lumbar degenerative disc disease with multilevel disc protrusion, lumbar spondylosis and lumbar myofascial pain. There is no record of a recent diagnostic study. Treatment to date has included physical therapy, trigger point injections and medication management. In a progress note dated 4/6/2015, the injured worker complains of neck pain that radiates total assistance he left shoulder and left upper extremity and low back pain. Physical examination showed cervical spine tenderness in the paraspinal region and muscle spasm with range of motion in the cervical spine. Shoulder motion produced pain in the cervical spine and there is trapezial tenderness on the left. The treating physician is requesting cervical epidural steroid injection to cervical 4-5, 5-6 and 6-7 and a motorized cold therapy unit purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical ESI at C4-5, C5-6, C6-7 times 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: Cervical ESI at C4-5, C5-6, C6-7 times 1 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that one of the criteria for the use of epidural steroid injections is that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The documentation does not indicate physical exam findings of radiculopathy in the proposed area for epidural steroid injection. The MTUS states that no more than two nerve root levels should be injected using transforaminal blocks and no more than one interlaminar level should be injected at one session. The request exceeds the recommended number of level of injections recommended by the MTUS. Furthermore, the documentation does not reveal objective imaging or electrodiagnostic studies. Additionally, the physical exam is not clear that there is a radiculopathy present in the proposed level of injections. For all of these reasons the cervical epidural steroid injection at C4-5, C5-6, C6-7 times 1 is not medically necessary.

Motorized CTU purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross/Blue Shield Medical Policy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back- Continuous-flow cryotherapy and Low back-cold/heat packs.

Decision rationale: The request for a motorized cold therapy unit is not medically necessary per the MTUS and the ODG guidelines. The MTUS does not specifically discuss cooling devices but does advocate at home application of ice packs in acute conditions. The ODG states that continuous flow cryotherapy is not recommended in the neck. The ODG states that there is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function there is no indication in the documentation why the patient cannot use cold packs. There is no medical indication the patient needs a mechanical cooling system over an at home ice pack. The request for motorized cold therapy unit is not medically necessary.