

Case Number:	CM13-0014613		
Date Assigned:	03/26/2014	Date of Injury:	07/23/2009
Decision Date:	04/24/2014	UR Denial Date:	08/08/2013
Priority:	Standard	Application Received:	08/21/2013

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 50 year old male who was injured on 07/23/2009 while he was working on a pressing machine, his foot pressed a pedal by accident, and his right fingers became caught. Prior treatment history has included Neurontin, Tramadol, topical Dendracin and omeprazole. The patient attended group therapy for depression. 08/01/2013 Medications Include: Neurontin 600 mg Tramadol Dendracin Omeprazole 04/04/2013 Medications Include: Omeprazole 20 mg Anaprox 550 mg po twice daily #60 Tramadol ER 150 mg 1 tab a day #30 Dendracin 120 mg topical analgesic lotion Neurontin 300 mg tid #90 Diagnostic studies reviewed include MRI dated 02/20/2013 revealed: 1) Magnetic susceptibility artifacts are seen at the dorsal aspect of wrist joint 2) Scaphoid bone is not visualized; abnormal signal noted at its bed appearing hypo intense on T1W and hyper intense on T2W/STIR images 3) Marrow edema at the proximal aspect of trapezoid and capitates 4) An accessory ossicle at the radial aspect of trapezium is suggestive of epitrapezium/paratrapezium 5) Hypoplastic hook of hamate 6) Cysts in triquetral and hamate bone [REDACTED] note dated 01/08/2013 indicated the patient was using analgesic medications and Dendracin which he found to be very helpful in managing his pain though pain relief was only partial and temporary. He had pain in his right upper extremity which was worsening particularly his right hand with some numbness associated. His pain radiated into his right shoulder. He reported daytime somnolence and 5 pound weight gain. The patient described his pain as sharp, pressure like, cramping, and burning with pins and needles sensation. The pain was aggravated by bending forward, reaching, walking, doing exercises, and pushing shopping cart and leaning forward. The pain was relieved with rest, medication, ice, and relaxation. The patient had stopped seeing psychologist due to lack of financial resources for driving but reporting of 75% improvement with prior treatment. Objective findings on exam revealed a non-antalgic gait. Musculoskeletal exam of the cervical

spine revealed range of motion was full in all planes of the cervical spine. Inspection of the cervical spine revealed normal alignment without asymmetry or kyphosis. There was tenderness to palpation over the bilateral cervical paraspinous muscles. There was no spinous process tenderness or masses palpable along the cervical spine. There was negative Spurling's maneuver bilaterally. On motor strength testing, there was normal bulk and tone in all major muscle groups of the upper and lower extremities. No atrophy was noted; Motor strength was 5/5 and symmetric throughout the bilateral upper extremities. His sensory exam was intact to light touch and pinprick throughout the upper and lower extremities; Deep tendon reflexes were normal; Reflexes were symmetric at 2+/4 in the bilateral upper extremities and 2+/4 in the bilateral lower extremities. There was negative bilateral Hoffman's, negative Babinski and negative clonus signs. The patient was diagnosed with reflex sympathetic dystrophy of the upper limb, displacement of cervical intervertebral disc without myelopathy, and chronic pain syndrome. [REDACTED] dated 04/04/2013 documented the patient had complaints of pain in his right upper extremity is worsening. His pain radiated into his right shoulder. He rated the severity of the pain as 7. He described his pain as sharp, pressure like, cramping, and burning with pins and needles sensation. The pain was aggravated by bending forward, reaching, walking, doing exercises, and pushing shopping cart and leaning forward. The pain was relieved with rest, medication, ice, and relaxation. Objective findings on exam revealed normal bulk and tone in all major muscle groups of the upper extremities; motor strength was 5/5 and symmetric throughout the bilateral upper extremities; sensation exam was grossly intact to light touch and pinprick throughout the upper extremities. His deep tendon reflexes were symmetric at 2+/4 in the bilateral upper extremities and 2+/4. He had negative bilateral Hoffmann's. The patient was diagnosed with reflex sympathetic dystrophy of the upper limb and displacement of cervical intervertebral disc without myelopathy. The patient had a psychological evaluation on 03/05/2013. He is currently involved with psych individual and group therapy sessions which is helping him. Group physical therapy progress note dated 03/26/2013 indicated the patient was calm and cooperative. The patient was attentive and participated actively in group. The patient participated in 9 sessions of CBT group therapy for depression. The patient was diagnosed with MDD but the patient denies suicidal ideation. The patient appeared to be responding well to group therapy. The patient was instructed to continue attending sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

MULTIDISCIPLINARY EVALUATION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 31-32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Multidisciplinary Pain Management Programs Page(s): s 31-32.

Decision rationale: Absence of other options likely to result in pain improvement has not been established, as conservative care measures have not been exhausted. Specifically, a recent psych evaluator opined that the patient has received suboptimal psychiatric treatment to date. Further, the patient does not appear to have a significant loss of ability to function independently given a normal physical examination without evidence of functional deficit. Finally, negative predictors of success, in particular psychosocial distress, do not appear to have been addressed. Therefore, multidisciplinary evaluation is non-certified.