

Case Number:	CM13-0063153		
Date Assigned:	12/30/2013	Date of Injury:	07/14/2011
Decision Date:	04/03/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational and Environmental Medicine, and is licensed to practice in Oklahoma and 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 physician 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 44 year old female who was injured on 7/14/11. Prior treatment history has included physical therapy, Norco 2.5mg, Anaprox, Terocin patches, and Prozac. The patient underwent an injection to the shoulder/upper traps area that provided significant moderation of her shoulder pain. A triple phase bone scan performed on 3/27/13 revealed no evidence for reflex sympathetic dystrophy/complex regional pain syndrome. An MRI of the cervical spine performed on the same date revealed no disc herniations. A PR-2 note dated 3/26/13 documented the patient to have complaints of persistent but less intense neck pain. She has completed the recommended acupuncture sessions and stated it resulted in moderation of her neck pain. She also noted physical therapy had helped to stabilize her shoulder complaints. At this time, she was complaining of persistent shoulder pain that produces difficulties with her activities of daily living. She also reported symptoms of depression and anxiety that she stated were discussed at a recent deposition. A note dated 10/9/13 documented the patient to have complaints of anxiety and depression. The symptoms began after being off work in July 2011 and not having the financial support to pay all the bills. Her anxiety got worse. When she was having an anxiety attack, she described having shortness of breath and she gets restless. When she feels depressed, she does not eat. She stated that her anxiety and depression resolved after her old worker's compensation claim resolved and was able to move on. She used to take depression medications, but she stopped because she does not like the way they made her feel. She reported she was getting migraines frequently. She took Maxalt, which she stated was helping. It was noted that [REDACTED] deferred the issues of sleep, anxiety, shortness of breath, weight loss and loss of interest to a pain management specialist. A PR-2 note dated 11/7/13 documented the patient to have complaints of a more elevated pain level involving the neck with associated headaches. The patient complained of constant pain and stiffness. The patient complains of a stabbing, piercing

shoulder pain that she states is also more intense due to recent cold. Objective findings on exam included moderate tenderness to palpation along the sub occipital and paraspinal muscle, right greater than left, with significant guarding and moderate spasm of the right trap bundle and parascapular stabilizers. The tight shoulder had restricted range of motion. A PR-2 note dated 12/9/13 documented the patient to have complaints of flare-ups of her neck pain and associated headaches. Objective findings on exam included moderate tenderness to palpation along the neck paraspinal muscles, right greater than left, with palpable TVP/ inclination that reproduced her headaches' pain pattern. A follow-up note dated 12/16/13 documented the patient to have complaints of neck pain and right-sided shoulder pain. She is considering operative intervention, but has not made a decision yet. Her opioid medications were reduced from 7.5mg to 2.5mg. A note dated 12/22/13 indicated the patient had a comprehensive consultation psychosocial pain management evaluation on 12/12/13 which revealed she had developed increasing pain in the right shoulder on a cumulative trauma basis. Her right shoulder pain eventually radiated to her neck, right inner elbow and right biceps. At that time, the patient was experiencing psychosocial symptoms and complaints including depression, anxiety, sleeplessness, and loss of interest in sexual activities. It has adversely affected her sex life, sleep pattern, etc. Furthermore, the patient reported that as a result of the psychosocial symptoms and complaints secondary to the chronic pain from work-related injuries, she was experiencing irritability and fatigue towards her children. She is feeling depressed most of the time. She reported interrupted sleep in five hours and experiencing anxiety attacks

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for a cognitive psychosocial evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 387-388, 391-392.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 387-388.

Decision rationale: Per the California MTUS/ACOEM, the majority of patients with stress-related conditions will not have red flags and can be safely and effectively managed by occupational or primary care physicians. Relief of stress depends on its precipitants, which are often multifactorial. Psychological, workplace, or socioeconomic issues can be explored with the patient to facilitate early identification of precipitating factors and appropriate interventions that may prevent delayed recovery or relapse. An open, honest discussion of the underlying factors often results in increase in the patient's insight and coping skills, which itself helps alleviate many stress-related symptoms. Patients are encouraged to enhance their individual coping skills to decrease or discontinue maladaptive coping mechanisms such as excessive use of alcohol, tobacco, or other drugs, or excessive food intake. Patients are counseled to redirect their energies to regular aerobic exercise, relaxation techniques, and cognitive coping mechanisms. If symptoms become disabling despite primary interventions or persists beyond three months, referral to mental health professionals is indicated. The initial assessment is a critical tool for detecting potential emotional problems that require the attention of a psychiatrist or other mental

health professional to assure safe and optimal treatment. The initial screening should be focused more on recognizing indications for urgent mental health referrals (red flags) than on specific psychiatric diagnoses. Red flag indicators include impairment of mental functions, overwhelming symptoms, or signs of substance abuse. The practitioner performing the assessment is advised to keep a highly index of suspicion for depression, which is a prevalent and underdiagnosed condition. Absence of red flag indicators rules out the need for urgent referral or inpatient care. A trial of mental health primary care or occupational medicine interventions is warranted before a cognitive psychosocial evaluation should be granted. As such, the request is noncertified.