

Case Number:	CM14-0112552		
Date Assigned:	08/01/2014	Date of Injury:	08/04/2011
Decision Date:	09/09/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	07/18/2014

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 Family 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:

This now 45-year old room attendant struck her L hand on a sink backsplash board on 8/4/11, resulting in bruising and minor swelling of the hand. Body parts included in this injury increased over time, and her current diagnoses now include bilateral carpal tunnel syndrome, and cervical sprain/strain. Treatment has included medications, multiple physical therapy sessions, L carpal tunnel release on 10/27/11 and R carpal tunnel release on 11/20/13. The patient's symptoms did not improve enough for her to return to work at any time for which there are available records. UR notes document a cervical MRI performed on an unknown date, which revealed multilevel degenerative changes with small disc bulges and protrusions, which did not result in significant canal or neuroforaminal narrowing. The surgeon who performed her last carpal tunnel release has continued to follow her. His exam notes largely document her as having mild neck, shoulder and wrist pain, with either stiff or normal neck ROM. Neurological exam is documented as intact in upper extremities. There are multiple PT notes in the record, which document muscle tenderness but do not document neurological deficit or other signs suspicious for cervical nerve root impingement. On 3/6/14 the surgeon requested authorization for a referral for pain management and consultation for epidural steroid injection, and repeated the request on 4/29/14. By 5/29/14 he was documenting the request as pain management (previously requested). On 6/7/14 he submitted a request for approval for pain management, PT 2x6, and a psychiatric consultation for nightmares. The request for pain management was denied in UR on 6/16/14, and the request for PT was modified to authorized 6 visits only.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 43-44, Chronic Pain Treatment Guidelines Criteria for Epidural Steroid Injections Page(s): 46.

Decision rationale: According to the references cited above, determining whether a patient suffers from a pathologic condition may not always be straightforward. Workers may believe that they have a physical injury when the real problem is a lack of fit with their job duties. Such workers may present with the development of symptoms after a minor physiologic stress, and often may have multiple symptoms with non-specific physical findings.. Performing multiple procedures and tests in this setting is described as an incomplete or inaccurate approach to patient assessment that may set the stage for the prolongation of medical care, delayed recovery and the development of a range of behaviors by the patient in order to prove that there is a real injury that precludes return to work. It appears likely that this patient is one of those described above. A referral for pain management and epidural steroids in this setting is likely to reinforce this patient's perception that she is injured and unable to work, and to prolong her treatment and disability. In cases of delayed recovery and prolonged time away from work, the clinician should determine whether specific obstacles are preventing the patient from returning to work. The clinician should judiciously select and refer to specialists who will support functional recovery as well as provide expert recommendations. The clinician should always think about differential diagnoses. This should involve stepping back and reevaluating the patient and the entire clinical picture. Symptoms or physical findings that have developed since the injury that may not be consistent with the original diagnosis. A detailed history and physical exam should be conducted. Appropriate studies may be performed. The first step in managing delayed recovery is to document the patient's current state of functional ability. Goals for functional recovery can then be framed with reference to this baseline. None of these actions have been taken in this case. There has been no careful reassessment of this patient's history and physical exam. There has been no functional assessment. A reference is made to nightmares without any explanation in the progress notes. If this patient is having unusual nightmares here are multiple possible explanations, none of which should result in a referral for pain management and epidural steroid injections. Finally, since referral for epidural steroid injections appears to be the primary reason for this referral, it should be pointed out that she does not meet the criteria for these injections. There are no signs of radiculopathy consistently documented in the record, the MRI results are not consistent with nerve root compression, and no electrodiagnostic testing has been performed. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Referral for pain management is not medically necessary based on the lack of sufficient assessment to determine that it is needed, and the possibility that it would result in prolongation of the patient's disability.