

Case Number:	CM14-0065221		
Date Assigned:	07/11/2014	Date of Injury:	08/13/2012
Decision Date:	09/24/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/08/2014

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 Internal Medicine, and is licensed to practice in Arizona. 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 is a 64-year-old female who worked as an airline host for 18 years. On March 10, 2004 she fell, sustaining injuries to right hip, right knee and right sacroiliac joint. She returned to work. Then on August 13, 2012, she fell again, causing problems particularly to the right shoulder, left hand and wrist and lower back. She has been unable to return to work. A March 24, 2014 Qualified Medical Examiner listed her diagnoses as Right shoulder impingement syndrome, rotator cuff tendinitis, and rotator cuff tear, Status post right shoulder arthroscopy with subacromial arch decompression and open rotator cuff repair on March 25, 2013, Lumbosacral spine strain/sprain, Lumbar spine multilevel disc bulges and spondylosis with disc degeneration, Comminuted fracture, distal left radius, Status post (ORIF) open reduction and internal fixation of comminuted fracture, distal left radius on August 17, 2012, Left carpal tunnel syndrome and stenosing tenosynovitis, left thumb and Status post left carpal tunnel release and A1 pulley release, left thumb on June 14, 2013. Rule out carpal tunnel syndrome right wrist. Her current medications include Aleve as needed and Norco 5/325 mg 2 tablets/day. She had physical therapy (PT) for both the wrist and lower back. There are no PT notes to indicate the number of visits and whether there was benefit. On April 16, 2014 the same physician requesting more PT made a statement that her previous back PT did not help. With this same physician, her complaints were primarily related to left wrist as well a right-sided low back and buttock pain, stated to be a right L5 radiculopathy. He discussed the sequel associated with her chronic pain syndrome causing both a sleep and mood disorder. Her exam was significant for good range of motion of the left wrist. She had s stiff gait, marked straightening of the lumbar lordosis, myofascial trigger points in the lumbar paraspinous muscles with hyperalgesia in the right gluteal musculature. He leg lengths were markedly different due to an elevated right hemipelvis. She had a positive straight leg raise on the right with pain radiating into the manterior thigh. A

February 28, 2011 Lumbar MRI showed: Moderate degenerative disc disease at L1-L2 and L2-L3 with milder degenerative changes at other levels. She had multilevel disc bulges small, with multilevel facet arthrosis. She had mild multilevel neural foraminal stenosis. Because of the significant pain, an L5 radiculopathy noted on exam, a repeat lumbar MRI was requested along with a Physical Therapy Referral for the lumbar spine and left wrist pain. Because of the impact of her chronic pain on her mood and sleep a Psychology Referral was placed. The purpose of this Independent Medical Review is to determine if 6 physical therapy visits for the wrist and lumbar spine and a referral for 6 Pain Psychology Visits is medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x6 left wrist and lumbar: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2- Pain Interventions and Treatments Page(s): 74.

Decision rationale: It is assumed that she completed her recommended post-surgical visits. The documentation does not provide a record of the patient's frequency of visits after her two left wrist surgeries (left wrist Open Reduction and Internal Fixation and Carpal Tunnel Repair). She is now beyond the post-surgical timeframe and is now under the purview of the MTUS, Chronic Pain Treatment Guidelines. Under Physical Medicine, it is stated that "...Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with and without mechanical assistance or resistance and functional activities with assistive devices...." Regarding the lower back, the documentation, again, does not provide a record of when she had therapy or what was the frequency of visits completed. There was no elaboration of the physician's statement that the physical therapy did not work, so it is difficult to understand why he ordered PT again. The MTUS further states: "...In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates for 64.7% among those in having treatment recommendations versus 36.5% for passive treatment." It is possible that this patient could benefit from more physical therapy; however, there is nothing in the documentation that is compelling to provide additional therapy over what she has already completed. The MTUS has the following Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to three visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over eight weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8 to 10 visits over four weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. For the reasons stated above, it is deemed not medically necessary to obtain further physical therapy (6 visits) for the left wrist and lumbar spine.

Pain psychology x6 left wrist and lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment and Psychological evaluations.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavior Interventions, Psychological treatment Page(s): 23, 101, 102.

Decision rationale: The MTUS clearly recommends Behavior Interventions stating: The identification and reinforcement of coping skills is often more useful in the treatment of pain and ongoing medication or therapy, which could lead to psychological or physical dependence... Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Then, consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone: Initial trial of 3-4 psychotherapy visits over 2 weeks, then, with evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions). Additionally, the MTUS states that Psychological Treatment is recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing comorbid mood disorders (such as depression, anxiety, panic disorder, and post-traumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on returning to work. The following stepped care approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasized self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point, a consultation with the psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained despite continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. Based on the above criteria, 6 visits for Pain Psychology are not deemed medically necessary. The patient should undergo the suggested psychologist screening and then if she is an appropriate candidate she likely could undergo an initial trial of 3-4 psychotherapy visits over 2 weeks, then, with evidence of objective functional improvement, a total of up to 6-10 visits over 5-6 weeks (individual sessions).