

Case Number:	CM15-0106158		
Date Assigned:	06/10/2015	Date of Injury:	07/19/2006
Decision Date:	07/16/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/02/2015

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: California, Arizona, Maryland
Certification(s)/Specialty: Psychiatry

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 55-year-old male who sustained an industrial injury on 7/19/06 of amputation of his left middle finger, partial amputation of his left fourth finger and injured his left index finger. Diagnoses include left shoulder pain, complex regional pain syndrome-left upper extremity, chronic pain syndrome, status post left middle finger amputation and left ring finger amputation with severe neuropathic pain and phantom pain. In a treating physician progress note dated 4/22/15, the injured worker reports subjective complaints of neck pain, radiating down the left upper extremity which is aggravated by activity and walking, low back pain radiating down the left lower extremity, and upper extremity pain in the left shoulder, hand and arm. The pain is constant and is aggravated by activity and walking. His pain is described as aching, sharp, throbbing and moderate in severity, accompanied by muscle weakness and numbness and is associated with insomnia and itching (phantom sensation) with missing fingers. Also noted is insomnia associated with depression, associated with ongoing pain, associated with anxiety, stable with medications. Pain is rated as 4 out of 10 in intensity with medications and 8 out of 10 without medications. The injured worker reports ongoing activity of daily living limitations with care and hygiene, activity, ambulation, hand function, sleep and sex due to pain. Per the physician progress note dated 4/22/15, the Beck Depression Inventory was administered on 3/25/15 and the total score was 45 and based on the findings of moderate to severe depression, further evaluation is indicated and a referral to a psychiatrist or psychologist may be considered. The Insomnia Severity Index was administered on 3/25/15 with a total score of 27 and based on this score it was determined he has severe clinical insomnia. The Neck Disability index questionnaire was administered on 3/25/15 with a score of 68% representing the injured worker perceived functional level of crippled functional disability. It is also noted that he has developed opiate tolerance due to long term use. The upper extremity exam notes tenderness on palpation at the left anterior shoulder, left elbow and left hand with mild swelling of the left

hand. Range of motion of the left shoulder was decreased due to pain and extension was 45 and abduction was 100. Sensory exam shows a decrease to touch sensation in the left upper extremity and the affected dermatome is cervical 6-7. Motor exam shows decreased strength of the extensor muscles along the cervical 4-6 dermatome in the left upper extremity. Deep tendon reflexes in the brachioradialis were decreased on the left and grip strength on the right was 30, 30, 30, and on the left was 10, 10, 10. Associated findings include hypersensitivity, allodynia, discoloration and temperature changes in the right upper extremity. Per the physician progress noted dated 4/22/15, the injured worker is status post Stellate Ganglion Block on 2/3/15 and he reports 50-80% overall improvement and good functional improvement with concentration, mood, sleep and improved mobility. There was a comprehensive psychodiagnostic re-evaluation done on 5/7/15, which notes objective psychodiagnostic testing reveals severe depression, severe anxiety, severe hopelessness, severe internal turmoil. Axis I diagnoses listed from this visit are post traumatic stress disorder, major depressive disorder, pain disorder associated with both psychological factors and a general medical condition. Prior treatment has included occupational therapy, Vicodin, Prozac, Ambien, Norco, Temazepam, Mirtazipine, Doxepin, Duloxetine, Venlafexine, Neurontin, Voltaren gel, Lidocaine gel, Fentanyl patch, Naloxone, H-wave stimulator, transcranial magnetic stimulations, biofeedback sessions, and psychiatrist and psychologist visits- total number to date is unclear. Work status is that he is currently not working and is permanently disabled. The treatment plan is for individual psychotherapy for pain management, twelve sessions with re-evaluation to determine if future treatment is warranted, to be seen in the office weekly, ongoing treatment regarding psychotropic medications, ongoing pain management treatment and may need an evaluation by orthopedics. Treatment requested is individual psychotherapy, twelve sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Individual Psychotherapy, twelve sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 23, 100-102.

Decision rationale: California MTUS states that behavioral interventions are recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain recommends screening for patients with risk factors for delayed recovery, including fear avoidance beliefs. Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using cognitive motivational approach to physical medicine. 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-With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions). The injured worker has been diagnosed with left shoulder pain, complex regional pain syndrome-left upper extremity, chronic pain syndrome, status post left middle finger amputation and left ring finger amputation with severe neuropathic pain and phantom pain. He suffers from psychological consequences of the industrial injury in form of post traumatic stress disorder, major depressive disorder, pain disorder associated with both psychological factors and a general medical condition. It has been indicated that he has undergone some psychotherapy

treatment so far, however there is no clear documentation regarding the number of sessions completed so far or any evidence of objective functional improvement with the same. The medical necessity of further psychotherapy treatment cannot be affirmed in the absence of this information. Also, the request for twelve psychotherapy sessions exceeds the guideline recommendations for a complete psychotherapy trial as quoted above. Thus, the request for Individual Psychotherapy, twelve sessions is excessive and not medically necessary.