

Case Number:	CM15-0106543		
Date Assigned:	06/10/2015	Date of Injury:	09/29/2014
Decision Date:	07/16/2015	UR Denial Date:	05/12/2015
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

Certification(s)/Specialty: Internal Medicine

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 37-year-old female, who sustained an industrial injury on 9/29/2014, due to performing her usual and customary job duties. She reported injury to her neck and bilateral upper extremities due to repetitive and continuous movements. The injured worker was diagnosed as having chronic pain syndrome, cervical sprain/strain and myofascial pain, and cervical brachial myofascial pain syndrome/thoracic outlet syndrome. Treatment to date has included diagnostics, physical therapy, chiropractic, and medications. Currently (4/27/2015), the injured worker complains of pain in her neck. Overall, she reported feeling much worse than on her initial evaluation, and she was missing work due to pain. She reported pain radiating from her neck to her arms and hands/fingers, with numbness and tingling. Pain was rated 6-9/10 and was described as burning, tingling, and shooting. A review of symptoms was negative for psychiatric complaints. Current medications included Tylenol, Nabumetone, and Gabapentin. She appeared tearful because of ongoing pain and frustration and had decreased range of motion in her neck. She was having dizziness with Neurontin and was recommended Lyrica. Her condition was described as complicated, with factors for delayed recovery. The treatment plan included evaluation and four sessions of cognitive behavioral therapy, along with magnetic resonance imaging scan of the brachial plexus, bilaterally. It was noted that previous diagnostic testing included electromyogram and nerve conduction studies of the upper extremities on 11/11/2014 and magnetic resonance imaging of the cervical spine on 12/08/2014. The PR2 report (4/28/2015) noted that cervical magnetic resonance imaging was unremarkable and electromyogram and nerve conduction studies were normal.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI scan of brachial plexus bilaterally: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Musculoskelet Surg 2013 Aug 97. Caranci F. Briganti F. La Porta M. ANtinolfi G. Cessarano E. Fonio P, Brunese L Coppolino F. Source department of advanced biomedical sciences unit of neuroradiology. Federico II University of Naples Via S. Pansini 5, 80131 Naples Italy. Indian J Radiol Imagin 2012 Oct 22. Pictorial essay: Role of magnetic resonance imaging in evaluation of brachial plexus pathologies. Lawancle M. Patkar DP, Pungavkar S. Source department of MRI Dr. Balabhal Nanavati Hospital Mumbai, India.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Up to date Topic 5266 and Version 22. 0.

Decision rationale: The brachial plexus constitutes the nerve roots from C5 to T1 and pathology results from a variety of etiologies including compression, transection, ischemia, cancer, radiation, and certain metabolic conditions. The brachial plexus is relatively inaccessible to direct investigation and most processes are deduced. The symptoms vary from acute to insidious. The acute symptoms often present with shoulder and arm pain. The insidious pain can manifest as progressive pain, evolving numbness, or weakness of selected muscles. Chronic symptoms often include muscle weakness, atrophy, and sensory loss. The above patient has a very complicated and complex presentation and has had a variety of treatment modalities and interventions but is still symptomatic. Brachial plexus injuries can be difficult to diagnosis and the information garnered from direct soft tissue visualization with bilateral MRI's may be helpful in further diagnosis and treatment. Therefore, the UR decision is overturned and medically necessary and the patient should be afforded an MRI.

Cognitive behavioral therapy, 1 evaluation and 4 sessions: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations, Cognitive behavioral therapy (CBT) Page(s): 100 and 101. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cognitive behavioral therapy (CBT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 391 to 398, Chronic Pain Treatment Guidelines Chronic pain chapter Page(s): 101 and 102.

Decision rationale: The chronic pain section states that in chronic pain it is often beneficial to have psychological intervention. This would include setting goals, understanding the patient's pain beliefs and cognitive functioning. The AECOM relates that cognitive behavior psychotherapy may be beneficial in stress reduction and that the idea is to change one's perception of pain, stress, and subjective approach to his disabilities and problems. This type of therapy has been found to be effective in short-term control of pain and also in treating the long term effects of pain and in facilitating return to work. The AECOM states that the initial patient assessment is critical for detecting emotional problems requiring referral to a psychiatrist. Red flag symptoms indicating an urgent referral to a psychiatrist or other mental health provider

include impaired mental functioning, overwhelming symptoms, or signs of substance abuse. The AECOM also states that psychological referral is often indicated if significant psychopathology or serious comorbidities are present. It also states that severe stress related depression and schizophrenia should be referred to a specialist. However, common conditions such as mild depression can be handled by the PCP. However, if the depression lasts for more than 6 to 8 weeks a psychiatric referral may be considered. Lastly, issues related to work stress or person- job fit may be handled with talk therapy with a Psychologist or other mental health professional. More serious conditions should be sent to a Psychiatrist for consideration of treatment with medication. The above patient was noted to be tearful and frustrated by her chronic symptoms. From this we deduce that cognitive therapy would be beneficial in guiding her in the perception of her pain and limitations. Psychological counseling is often a very useful tool in treating chronic pain patients. Therefore, the UR decision is overturned and the patient should be afforded cognitive behavioral therapy, therefore making it medically necessary.