

Case Number:	CM15-0136888		
Date Assigned:	07/24/2015	Date of Injury:	12/31/2013
Decision Date:	08/21/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	07/15/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 34 year old female, who sustained an industrial injury on 12/31/13. Initial complaint was of the right upper extremity pain due to repetitive motion. The injured worker was diagnosed as having complex regional pain syndrome right upper extremity. Treatment to date has included physical therapy; TENS unit; medications. Diagnostics studies included EMG/NCV study upper extremities (4/15/14). Currently, the PR-2 notes dated 6/11/15 indicated the injured worker complains of right arm pain. She has been diagnosed with complex regional pain syndrome, type II upper limb/right arm and injury of the ulnar nerve. She is in this office for a pain medicine consultation. He reviews her clinical history and notes her surgery of ulnar nerve transposition on 9/15/14. Prior to this surgery, she was treated with physical therapy and splinting. Postoperatively, she has physical therapy but experienced significant flare and it was discontinued. She began using a TENS unit. Recently, he notes, she was found not to be a surgical or injection candidate and so it was suggested pain management. Her primary complaint on this date is documented as right upper extremity pain, numbness, tingling and burning. The character of her pain is constant with intermittent exacerbations. The quality of the pain is described as sharp, burning, tingling and dysethetic. It involves both the right elbow but into the ulnar nerve distribution of the right hand. The intensity of pain is said to be 6/10 with aggravating factors associated with writing, gripping, squeezing, driving, mouse use and typing. Alleviating factors of the pain include rest, medications and TENS unit as well as stretching. She is prescribed and taking both Gabapentin and Tramadol daily to control her symptoms. On physical examination, the provider documents, her shoulder girdles were asymmetric with right

shoulder higher than the left. Cervical range of motion was full to flexion-extension and rotation bilaterally. The bilateral glenohumeral range of motion was full to abduction and flexion. She has well-healed scar consistent with an ulnar nerve release at her right olecranon groove. She is very tender to palpation with associated allodynia and hyperalgesia. There is noted atrophy of the hypothenar compartment of the right hand, which is her dominant hand. She has marked loss of pinch strength in the right upper extremity. She had hypesthesia in the right upper extremity in the ulnar nerve distribution and there are multiple myofascial trigger points in the trapezius muscle on the right. The provider notes the ulnar nerve release helped her but it has been complicated by a causalgia with persistent burning pain and dysesthesia in the ulnar distribution. Associated with this is some atrophy of the distribution of the ulnar nerve in the right upper extremity, which is her dominant upper extremity. She has a job to return to, but is not capable at this point to perform any type of repetitive right upper extremity use. He recommends chronic pain psychology and physical therapy at this time. The provider is requesting authorization of pain psychology 6 sessions and physical therapy 6 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain psychology 1 x 6: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 102.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines psychotherapy Page(s): 101-102.

Decision rationale: The California chronic pain medical treatment guidelines section on psychological treatment states: 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 co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic 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 return 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 emphasize 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 a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. See also ODG Cognitive Behavioral Therapy (CBT) Guidelines. (Otis, 2006) (Townsend, 2006) (Kerns, 2005)

(Flor, 1992) (Morley, 1999) (Ostelo, 2005) Psychological treatment in particular cognitive behavioral therapy has been found to be particularly effective in the treatment of chronic pain. As this patient has continued ongoing pain, this service is indicated per the California MTUS and thus is medically necessary.

Physical therapy 2 x 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

Decision rationale: The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). 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 or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. 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 were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines -Allow for fading of treatment frequency (from up to 3 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 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2): 8-10 visits over 4 weeks; Reflex sympathetic dystrophy (CRPS) (ICD9 337.2):24 visits over 16 weeks; The goal of physical therapy is graduation to home therapy after a certain amount of recommended sessions. The patient has already completed physical therapy. The request is in excess of these recommendations per the California MTUS. There is no objective reason why the patient would not be moved to home therapy after completing the recommended amount of supervised sessions in the provided clinical documentation. Therefore, the request is not medically necessary.