

Case Number:	CM15-0034479		
Date Assigned:	03/02/2015	Date of Injury:	05/28/2013
Decision Date:	09/17/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/24/2015

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 (IW) is a 63 year old female who sustained an industrial injury on 05/28/2013. She reported a traumatic worksite assault in which she was attacked, and knocked down, kicked and robbed. She suffered a fracture of the left middle finger. The injured worker was diagnosed as having a fractured left index finger, neck, back and shoulder pain. Treatment to date has included radiologic imaging, physical therapy for the left shoulder, acupuncture to the neck and shoulder, medications, biofeedback, psychotherapy and psychotherapy and group psychotherapy. A functional capacity evaluation was done 03/27/2015. Currently, the injured worker complains of ongoing non-radiating aching, nagging pain in the left shoulder. She rates the pain a 3 on a scale of 0-10. The pain is intermittent and lasts less than 1/3 of the day. The pain is exacerbated by activity and stress. It is relieved by massage, relaxation and stretching. The pain also reports difficulty sleeping secondary to anxiety. The shoulder range of motion is limited by pain. Her strength is slightly weak. Reflexes are normal. She has a diagnosis of frozen shoulder, bicipital tenosynovitis, and myofascial pain/myositis. No medications are noted. On the Psychological symptoms, in the exam of 01/05/2015, she is not prescribed any psychotropic medications; her Beck Depression Inventory (BDI) on 11/04/2014 was 49. Her current score is 47 which indicate no change in her depression. Her Beck Anxiety Inventory (BAI) from 11/14/2014 was 19; her BAI on 01/05/2015 was 30 which indicate an increase in her anxiety. She has symptoms of depression and anxiety and endorses symptoms of post-traumatic stress disorder lasting over one month. She has experienced major depression and PTSD. The treatment plan is for additional cognitive behavioral therapy (CBT) due to chronic pain and co-

morbid mood disorders (11/04/2014), and additional biofeedback and acupuncture. A request for authorization was made for the following: 1. Follow up office visit; 2. A request for authorization was made for the following: 3. Cognitive behavioral therapy qty: 10; 4. Biofeedback therapy qty: 10; 5. Acupuncture qty: 6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow up office visit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 89.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back and other sections, Office visits.

Decision rationale: In this case, the injury was a few years ago, and the patient continues to be seen for chronic subjective pain complaints. There is little in the way of objective improvements or functional improvements, or growing independence from the health care system noted, which is a MTUS goal. Regarding office visits specifically, the MTUS is silent. The ODG notes that office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. In this case, it is again not clear what functional objective improvements are being achieved, and what would be added by a repeat office visit as opposed to independent self care at this point. The request is appropriately not medically necessary.

Psycho pharmacologic management referral: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 89.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

Decision rationale: This is a request for a referral in order to manage medication. ACOEM Guidelines, Chapter 7, Page 127, state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. It is not clear why medication management would need a referral. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. This request for the medication referral/consult fails

to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. At present, the request is not medically necessary.

Cognitive behavioral therapy qty: 10: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, stress and mental section, under Cognitive Therapy for Depression.

Decision rationale: The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. ODG Psychotherapy Guidelines note: Initial trial of 6 visits over 6 weeks; With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions). In the course of the records, I did not find documentation of objective improvement in function through past interventions. There is no DSM-IV analysis noted of the patient's conditions to warrant this form of therapy. It is not clear what cognitive behavioral therapy would add to the objective functional improvement given a lack of success in a broad array of measures. The request is appropriately not medically necessary.

Biofeedback therapy qty: 10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Biofeedback Page(s): 24-25.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24 of 127.

Decision rationale: Regarding Biofeedback, the MTUS chronic pain guidelines note that it truly is not recommended as a stand-alone treatment, but recommended as an option in a cognitive behavioral therapy (CBT) program to facilitate exercise therapy and return to activity. The ODG biofeedback therapy guidelines note the patient should be screened for risk factors for delayed recovery, as well as motivation to comply with a treatment regimen that requires self-discipline. Initial therapy for these "at risk" patients should be physical medicine exercise instruction, using a cognitive motivational approach to PT. Biofeedback is considered after psychotherapy. In this case, cognitive behavioral therapy was not certified, so this would be a standalone treatment, which is not supported. Further, the patient's motivation is not addressed. The request is appropriately not medically necessary.

Acupuncture qty: 6: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The MTUS notes frequency and duration of acupuncture or acupuncture may be up to 6 treatments to confirm functional improvement. Acupuncture treatments may be extended only if true functional improvement is documented as defined in Section 9792.20(f). There is no objective documentation of effective functional improvement in the claimant. There has been past acupuncture, without mention of what the objective, functional improvement has been. The sessions are appropriately not medically necessary under the MTUS Acupuncture criteria.