

Case Number:	CM15-0050364		
Date Assigned:	03/23/2015	Date of Injury:	10/01/2011
Decision Date:	05/01/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/17/2015

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: Emergency 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 49 year old female, who sustained an industrial injury on 10/01/2011. Initial complaints reported included. The initial diagnoses were not provided. Treatment to date has included conservative care, medications, physical therapy, MRI of the right wrist, injections, and a trigger finger release. Per the progress report dated 2/7/15, the injured worker complained of daily pain to the right elbow, wrist and hand with pain rating of 4-8/10 with numbness and tingling in the right hand. Documentation states that patient reports "depression". Patient is currently not working. Objective exam reveals wrist tenderness, carpometacarpal and 1st metacarpal joint. Range of motion is limited by pain. There is noted 4/5 weakness. Shoulder also has noted pain with positive Hawkins. Current medications include Ultracet, Lidoderm, Tramadol, Nalfon and Protonix. Current diagnoses include discogenic cervical condition with spasms, upper back sprain, lateral epicondylitis with MRI showing tendonitis, cubital tunnel syndrome, wrist joint inflammation, intersection syndrome, status post trigger finger release, and chronic pain syndrome. The treatment plan consisted of activity restrictions, conservative care measures, and follow-up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Consultation/referral to psychiatrist and psychologist for 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-101.

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

Decision rationale: As per MTUS Chronic pain guidelines, behavioral interventions for pain is often recommended. The provider has failed to document rationale for behavioral consultation and treatment. Patient has self reported "depression". There is no assessment or any documentation of this claim. There is no diagnosis of anxiety. The request also exceed guideline recommendation. Guidelines recommend initial 3-4 psychotherapy sessions over 2weeks and up to 10session if there is objective documentation of benefit. This request for consultation with psychologist is not medically necessary.

Consultation for Functional Restoration Program: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (functional restoration programs) Page(s): 30-32.

Decision rationale: As per MTUS Chronic pain guidelines certain criteria should be met before recommendation to a program. It requires: A functional baseline testing to measure baseline improvement. Fails criteria. Failure of prior chronic pain treatment. Fails criteria. There is no proper documentation of prior chronic management plan or conservative therapy attempted prior to FRP request. Loss of function due to pain. Meets criteria. Not a candidate for surgery. Nothing documented to support this criteria. Motivation to change. Fails criteria. Nothing is documented concerning plan for any change from patient's chronic pain and disability. Negative predictors for success has been addressed. Fails criteria. Nothing is documented concerning assessment for issues. Patient has yet to fail conservative therapy and treatment of his psychological issues to recommend FRP. Functional Restoration Program is not medically necessary.