

Case Number:	CM15-0170751		
Date Assigned:	09/11/2015	Date of Injury:	02/25/2013
Decision Date:	10/15/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	08/31/2015

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 61 year old female who sustained an injury on 2-25-13 resulted when she waited for back up assistance to arrive; she was repeatedly punched, kicked and assaulted by a 72 plus pound person. She had multiple bruises to her left leg and right arm; large raised blood clot on lower left leg; pain in her low back that radiated down both legs and pain in right shoulder that radiated into her neck and down her right arm to her wrist and hand. X-rays of the low back, neck and shoulder and MRI of the cervical spine and shoulder were performed on 8-13-13. Treatment included medications, epidural injection and recommended rest, physical therapy, surgery and brace. She was temporarily totally disabled. Medications included Terocin path, Cyclobenzaprine 5 mg, Maxalt, Zomig and Sumatriptan for migraine; Lexapro and Lunesta for depression and sleep disturbance. Diagnoses include headache; cervical sprain, strain; degeneration of lumbar intervertebral disc; lumbar annular tear; lumbar pain; lumbar radiculopathy; right shoulder myofascitis; right shoulder myofascitis; right shoulder sprain, strain; anxiety; sleep disturbance; constipation. 5-11-15 examination subjective complaints indicate cervical spine 15% improvement in neck right shoulder area; right sided neck and shoulder pain; stillness and tightness aggravated with movements. Low back pain improved by 25% in intensity and frequency; moderate amount of decreasing symptoms radiating to her legs. Primary complaint is the central lower back pain; tingling, numbness and pain to the legs and calves. Her symptoms limit her standing stationary to approximately 15 minutes and walking 20-30 minutes before the pain becomes significant. Right shoulder pain with stiffness and tightness aggravated with movement of the neck and shoulders. She ambulates without any assistance and does frequently getting out of the chair and change positions. Objective finding cervical spine

indicates on extension and right and left lateral bending there is pain in the central and right lower cervical spine and upper shoulder region. Lumbar spine has pain during extension and right and left lateral bending and the Kemp's test on the right reproduces significant right sided lumbar spine pain. Right shoulder and left shoulder abduction and flexion across the chest does not cause any shoulder pain. Chiropractic treatments (6) have had some benefit and an additional 4 treatments were requested. On 7-20-15, the examination indicates the previous symptoms in her cervical spine; right shoulder and lumbar spine. She had 4 additional chiropractic treatments authorized to improve pain levels and function of neck and back. Psychologically she complains of anxiety, depression, stress and resentment over her inability to work or travel. Current requested treatments cognitive behavioral training with biofeedback, 2 times a week for 2 weeks; physical therapy 2 times a week for 2 weeks, thoracic, lumbosacral spine; transcutaneous electrical nerve stimulation (TENS) unit, purchase thoracic, lumbosacral spine. The utilization review 8-26-15 denied all requested treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive behavioral training with biofeedback, 2 times a week for 2 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment.

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). Upon review of the submitted documentation, it is noted that the injured worker has been evaluated by a mental health professional as well as undergone treatments with a psychologist. As the 7/2/15 progress report, which was the most recent available for my review, did not identify what symptoms the CBT would target, medical necessity cannot be affirmed. Therefore, the request is not medically necessary.

Physical therapy, 2 times a week for 2 weeks, thoracic/lumbosacral spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Per MTUS CPMTG, physical medicine guidelines state: 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 (ICD 729.2): 8-10 visits over 4 weeks." The records submitted for review (specifically the January 2015 note which was the initial comprehensive chiropractic assessment) state that the patient has had 8-12 visits of physical therapy for the lumbar spine and shoulder with no improvement. It is indicated in the documentation that the prior physical therapy was for the lumbar spine and that the request is for the thoracic and lumbar spine. However, as the attending spine surgeon [REDACTED] felt her pain was attributed to lumbar radiculopathy primarily, this was appropriately targeted treatment. As the request is for more sessions than the recommended amount, the request is not medically necessary.

TENS unit, purchase, thoracic/lumbosacral spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines do not recommend TENS as a primary treatment modality, but support consideration of a one-month home-based TENS trial used as an adjunct to a program of evidence-based functional restoration. Furthermore, criteria for the use of TENS includes pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a documented one-month trial period stating how often the unit was used, as well as outcomes in terms of pain relief and function. As documentation of a one-month trial period is lacking, medical necessity cannot be affirmed. Therefore, the request is not medically necessary.