

Case Number:	CM15-0175954		
Date Assigned:	09/17/2015	Date of Injury:	05/29/2014
Decision Date:	11/16/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	09/08/2015

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, California
 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:

This is a 42-year-old female with a date of industrial injury 5-29-2014. The medical records indicated the injured worker (IW) was treated for cervical and lumbar spine sprain-strain; lumbar radiculitis; muscle spasms; triangular fibrocartilage complex tear, bilateral wrists; lumbar spine disc syndrome without myelopathy; carpal tunnel syndrome; and status post left carpal tunnel release and flexor tenosynovectomy (3-18-15). In the progress notes (8-4-15), the IW reported left wrist pain rated 7 out of 10, which she stated was well-controlled with medication. Cymbalta was prescribed for her chronic pain and depression. On 6-29-15, she reported low back pain rated 8 out of 10 with associated numbness, tingling and swelling in her legs and pain rated 5 to 6 out of 10 in the upper back, shoulder, elbow and ankle. On examination (8-4-15 notes), the carpal tunnel release scar on the left wrist was well-healed and there was tenderness at the wrist joint and at the carpal bones. Capillary refill was normal and there were no sensory deficits. Strength was 2+ out of 5. There was hypoesthesia of the left lateral thigh and mild inflammation of the left lower extremity without sensory deficit. Patellar and Achilles reflexes were equal and symmetrical. Strength was 2+ out of 5. Treatments included left wrist surgery (3-18-15), physical therapy, which was helpful, and medications. The IW was temporarily totally disabled. A Request for Authorization was received for a psychology consultation, supervised functional restoration program once a week for five weeks, range of motion and muscle testing. The Utilization Review on 8-24-15 non-certified the request for a psychology consultation, supervised functional restoration program once a week for five weeks, range of motion and muscle testing. Patient had received lumbar medial branch block in 1/2015. The medication list

included Duloxetine (Cymbalta). The patient had history of worsening of depression and radiculopathy. The patient had received an unspecified number of PT visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychology consultation: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter - Psychological evaluations.

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, IME and consultations.

Decision rationale: Per the cited guidelines, "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." The patient has had diagnoses of cervical and lumbar spine sprain-strain; lumbar radiculitis; muscle spasms; triangular fibrocartilage complex tear, bilateral wrists; lumbar spine disc syndrome without myelopathy; carpal tunnel syndrome; and status post left carpal tunnel release and flexor tenosynovectomy (3-18-15). Cymbalta was prescribed for her chronic pain and depression. The patient has had history of worsening of depression and radiculopathy. The management of this case would be benefited by a Psychology consultation. The request for referral to a Psychology consultation is medically necessary and appropriate for this patient.

Function restoration program (supervised) 1 time per week for 5 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): Functional restoration programs (FRPs).

Decision rationale: Per the cited guidelines "Criteria for the general use of multidisciplinary pain management programs-Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (6) Negative predictors of success above have been addressed." The criteria for a chronic pain management program have not been met as per the records provided. The patient has received an unspecified number of PT visits for this injury. A detailed response to previous conservative therapy was not specified in the records provided. The pain evaluation

of this patient (e.g. pain diary) was not well documented and submitted for review. Baseline functional testing that documents a significant loss of ability to function independently resulting from the chronic pain was not specified in the records provided. In addition, per the cited guidelines, "The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs." (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability). The patient has a history of depression. She was temporarily totally disabled. There is conflicting evidence that chronic pain programs would provide return-to-work in this kind of patient. The request for Function restoration program (supervised) 1 time per week for 5 weeks is not medically necessary for this patient.

Range of motion and muscle testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter - Computerized range of motion (ROM): Flexibility.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter Low Back (updated 09/22/15) Computerized range of motion (ROM) Flexibility.

Decision rationale: ACOEM and CA MTUS do not specifically address this request. Therefore ODG used. Per the ODG guidelines cited below "Not recommended as primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent." Range of motion testing and muscle testing is not recommended by the cited guidelines and the relation between range of motion measures and functional ability is weak. The patient has received an unspecified number of PT visits for this injury. The detailed response to previous conservative therapies was not specified in the records provided. The previous conservative therapy notes were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. The request for Range of motion and muscle testing is not medically necessary in this patient.