

Case Number:	CM15-0178136		
Date Assigned:	09/18/2015	Date of Injury:	06/18/2013
Decision Date:	11/10/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/10/2015

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 51 year old female who sustained an industrial injury on 6-18-13. A review of the medical records indicates she is undergoing treatment for cervical disc disorder, upper limb entrapment neuropathy, and shoulder pain. She also has a history of cervical degenerative disc disease, right rotator cuff tear, right median neuropathy, cervical and trapezius myofascial spasms, history of alcohol abuse, sober for 21 months, and pituitary brain tumor (non-industrial). Medical records (3-6-15 to 8-21-15) indicate ongoing complaints of neck pain, upper extremity pain, right shoulder pain, and right wrist pain. She reports that her neck pain radiates down to her bilateral upper extremities. It is associated with numbness, tingling, and weakness in the right arm and right hand. She rates the pain 10 out of 10. She describes it as "throbbing, dull, aching, pressure-like, and burning with muscle pain and pins and needles sensation". The physical exam (8-21-15) indicates restricted range of motion in the cervical spine with flexion limited to 40 degrees by pain and extension limited to 50 degrees by pain. Right and left lateral bending are limited to 30 degrees by pain. Bilateral lateral rotation is also restricted. Tenderness and tight muscle band is noted on the right side of the paravertebral muscles. There is also spinous process tenderness at C6 and C7, as well as tenderness at the paracervical muscles, rhomboids, and trapezius. The right shoulder range of motion is noted to be restricted. The right elbow and wrist are within normal limits. Diagnostic studies have included an EKG, a cervical MRI, electrodiagnostic studies of bilateral upper extremities, right shoulder MRI, and urine toxicology studies. Treatment has included medications, activity modification, right rotator cuff surgery, and acupuncture treatment. The request for

authorization (8-31-15) includes a referral to the pain management psychologist for evaluation for cognitive-behavioral therapy and pain-coping skills training, physical therapy for a total of 12 visits, and a trigger point injection of the cervical paravertebral; right trapezius. The utilization review (9-4-15) indicates modification of physical therapy to 6 sessions. The remainder of the requested services were denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral to Pain Management Psychologist: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic)/Psychological evaluations.

Decision rationale: The request is for an evaluation by a psychologist due to persistent pain. The official disability guidelines state the following regarding this topic: Recommended based upon a clinical impression of psychological condition that impacts recovery, participation in rehabilitation, or prior to specified interventions (e.g., lumbar spine fusion, spinal cord stimulator, implantable drug-delivery systems). (Doleys, 2003) Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. (Main-BMJ, 2002) (Colorado, 2002) (Gatchel, 1995) (Gatchel, 1999) (Gatchel, 2004) (Gatchel, 2005) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. (Gatchel, 1999) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. (Goldberg, 1999) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. (Linton, 2002) Other studies and reviews support these theories. (Perez, 2001) (Pulliam, 2001) (Severeijns, 2001) (Sommer, 1998) In a large RCT the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. (Lin-JAMA, 2003) See "Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients" from the Colorado Division of Workers' Compensation, which describes and evaluates the following 26 tests: (1) BHI 2nd ed - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory [has been superseded by the

MBMD following, which should be administered instead], (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 - Brief Battery for Health Improvement, (9) MPI - Multidimensional Pain Inventory, (10) P-3 - Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Symptom Checklist, (19) BDI-II - Beck Depression Inventory, (20) CES-D - Center for Epidemiological Studies Depression Scale, (21) PDS - Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ - McGill Pain Questionnaire, (24) MPQ-SF - McGill Pain Questionnaire Short Form, (25) Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale - VAS. (Bruns, 2001) Chronic pain may harm the brain, based on using functional magnetic resonance imaging (fMRI), whereby investigators found individuals with chronic back pain (CBP) had alterations in the functional connectivity of their cortical regions - areas of the brain that are unrelated to pain - compared with healthy controls. Conditions such as depression, anxiety, sleep disturbances, and decision-making difficulties, which affect the quality of life of chronic pain patients as much as the pain itself, may be directly related to altered brain function as a result of chronic pain. (Baliki, 2008) Maladjusted childhood behavior is associated with the likelihood of chronic widespread pain in adulthood. (Pang, 2010) Psychosocial factors may predict persistent pain after acute orthopedic trauma, according to a recent study. The early identification of those at risk of ongoing pain is of particular importance for injured workers and compensation systems. Significant independent predictors of pain outcomes were high levels of initial pain, external attributions of responsibility for the injury, and psychological distress. Pain-related work disability was also significantly predicted by poor recovery expectations, and pain severity was significantly predicted by being injured at work. (Clay, 2010) See also Comorbid psychiatric disorders. See also the Stress/Mental Chapter. In this case, the request is reasonable and supported by the documentation. The patient has chronic pain which justifies evaluation by a psychologist regarding pain management. As such, the request is medically necessary.

Physical Therapy for Neck and Right Wrist Qty 12: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck/Physical therapy (PT).

Decision rationale: The request is for physical therapy. The official disability guidelines state the following regarding this topic: ODG Physical Therapy Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial". Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0):9 visits over 8 weeks; Sprains and strains of neck (ICD9 847.0):10 visits over 8 weeks; Displacement of cervical intervertebral disc (ICD9 722.0):Medical

treatment: 10 visits over 8 weeks; Post-injection treatment: 1-2 visits over 1 week; Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks; Post-surgical treatment (fusion, after graft maturity): 24 visits over 16 weeks; Degeneration of cervical intervertebral disc (ICD9 722.4):10-12 visits over 8 weeks; See 722.0 for post-surgical visits; Brachia neuritis or radiculitis NOS (ICD9 723.4):12 visits over 10 weeks; See 722.0 for post-surgical visits; Post Laminectomy Syndrome (ICD9 722.8):10 visits over 6 weeks; Fracture of vertebral column without spinal cord injury (ICD9 805): Medical treatment: 8 visits over 10 weeks; Post-surgical treatment: 34 visits over 16 weeks; Fracture of vertebral column with spinal cord injury (ICD9 806): Medical treatment: 8 visits over 10 weeks; Post-surgical treatment: 48 visits over 18 weeks; Work conditioning (See also Procedure Summary entry):10 visits over 4 weeks; In this case the number of requested treatments is not supported by the guidelines. As stated, a "six-visit clinical trial" is indicated with continued therapy depending on the diagnosis. In this case, an initial 6 sessions are indicated. As such, the request is not medically necessary.

Referral to Orthopedic Surgeon for the Shoulder: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic)/Office visits.

Decision rationale: The request is for a specialty consultation. The MTUS guidelines are silent regarding this issue. The ODG state the following: 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. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor

interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. See also Telehealth. In this case, the request is not certified. This is secondary to poor documentation as to the reasoning for the visit and consultation as the patient has already undergone several consultations with orthopedists. Pending further information, the request is not medically necessary.

Trigger Point Injection to Cervical Paravertebral Right Trapezius: 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): Trigger point injections.

Decision rationale: The request is for a trigger point injection to aid in pain relief. The MTUS guidelines state the following regarding this topic: Recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. Not recommended for radicular pain. Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. (Colorado, 2002) (BlueCross BlueShield, 2004) In this case, as stated above, the patient does not qualify for this treatment modality. Patients who have any radicular symptoms present on exam or imaging preclude trigger point injection. As such, the request is not medically necessary.