

Case Number:	CM15-0039078		
Date Assigned:	03/09/2015	Date of Injury:	07/17/2012
Decision Date:	05/14/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/02/2015

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: Physical Medicine & Rehabilitation

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 41-year-old female who reported an injury on 07/17/2012. The mechanism of injury was not specifically stated. The current diagnosis include CRPS in the left lower extremity. The injured worker presented on 02/03/2015 for a follow-up evaluation regarding CRPS in the left lower extremity. The provider indicated the complex regional pain syndrome had spread to the left upper extremity. The injured worker had been previously treated with medication management and ketamine infusions with only a temporary relief of symptoms. The injured worker reported persistent pain and anxiety secondary to pain. The injured worker was status post left stellate ganglion block. Prior to the block, the injured worker reported 8/10 constant burning pain. The injured worker reported a relief of symptoms following the injection procedure. The current medication regimen includes levorphanol, Vicodin, gabapentin, Klonopin, baclofen, Cymbalta, Topamax, Dexilant, Biotin, magnesium citrate, ketamine and Phenergan. Upon examination, the injured worker appeared to be in a foggy state with her eyes slightly glazed over. Evaluation of the bilateral upper extremities demonstrated no allodynia direct or indirect. Mottling was present; however, symmetric in the bilateral upper extremities. Range of motion was full in all major joints. Left upper extremity strength was guarded. There was no documentation of hyperhydrosis or temperature asymmetry. The injured worker was ambulatory with a slightly antalgic gait. A small sclerotic vein was noted in the right forearm. Treatment recommendations at that time included continuation of the current medication regimen, 12 sessions of physical therapy, 6 sessions of psychotherapy, and continuation of the current medication regimen. A Request for Authorization was then submitted on 02/04/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hyperbaric Treatment, 10 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Infectious Disease Chapter, Hyperbaric oxygen therapy.

Decision rationale: The Official Disability Guidelines recommend hyperbaric oxygen therapy as an option in refractory cases. Hyperbaric oxygen therapy has been a useful adjunct to the treatment of refractory osteomyelitis. The injured worker does not maintain a diagnosis of osteomyelitis. The medical necessity for hyperbaric treatment has not been established in this case. As such, the request is not medically necessary.

Psychotherapy 10 sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Cognitive Behavioral Therapy.

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

Decision rationale: California MTUS Guidelines recommend cognitive behavioral therapy. Treatment is recommended as an initial trial of 3 to 4 psychotherapy visits over 2 weeks. The current request for 10 sessions of individual psychotherapy exceed guideline recommendations. Therefore, the request is not medically necessary at this time.

Neuro-Biofeedback 10 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines biofeedback therapy guidelines.

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

Decision rationale: California MTUS Guidelines do not recommend biofeedback as a standalone treatment, but recommend as an option in a cognitive behavioral therapy program. Treatment is recommended as an initial trial of 3 to 4 psychotherapy visits over 2 weeks. The request for 10 sessions of biofeedback exceeds guideline recommendations. As such, the request is not medically necessary.

Physical Therapy 10 sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. In this case, there was no documentation of objective functional improvement following the previous course of physical therapy. In addition, the course of physical therapy was recommended in conjunction with hyperbaric oxygen therapy, which has not been found to be medically necessary. The request as submitted also failed to indicate the specific body part to be treated. Given the above, the request is not medically necessary.

Unlimited Office Visits: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341.

Decision rationale: California MTUS/ACOEM Practice Guidelines state physician follow-up is appropriate when a release to modified, increased or full duty is needed or after appreciable healing or recovery can be expected. The request for an unlimited amount of office visits is not medically appropriate, as the injured worker would need to be reassessed at each office visit to determine further care. As such, the request is not medically necessary at this time.

Blocks as needed: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337.

Decision rationale: California MTUS/ACOEM Practice Guidelines state invasive techniques are not routinely indicated for the knee and leg. The specific type of block being requested was not listed. The specific quantity was not listed. While it is noted that the injured worker was status post a stellate ganglion block, there was no documentation of significant objective

functional improvement to support the necessity for additional procedures. Given the above, the request is not medically necessary at this time.

Adjuvant care as necessary (to include but not limited to Meditation, Restorative Yoga, Massage Therapy, Chiropractic adjustment, hypnosis or other interventional procedures/treatments as warranted): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints, Chronic Pain Treatment Guidelines Page(s): 60.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound and biofeedback have no scientifically proven efficacy in treating lower extremity symptoms. The request as submitted failed to indicate a specific quantity and body part to be treated. Given the above, the request is not medically necessary.