

Case Number:	CM13-0009164		
Date Assigned:	12/27/2013	Date of Injury:	03/28/2007
Decision Date:	02/19/2014	UR Denial Date:	07/11/2013
Priority:	Standard	Application Received:	08/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pediatric Rehabilitation Medicine, and is licensed to practice in Illinois, Indiana, and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 45-year-old male who reported a cumulative injury up to 03/28/2007. The mechanism of injury was repetitive in nature. The patient was diagnosed with "lumbogenic" low back pain. The patient continued to complain of constant low back pain. It is in the middle of the back. The patient reported that the pain radiates to both groins. It also radiates to both lower extremities, but more so on the right posteriorly down to the foot. The patient rated the pain at a 4/10. The patient stated the pain worsens with activity. The patient reported a slight decrease in pain with Motrin. The physical examination revealed palpable tenderness at the mid-lower lumbar spine. The patient had fairly full flexion and extension. The patient had slightly decreased range of motion bilaterally. The patient had a positive straight leg raising on the right causing pain down the posterior leg. The motor strength was stated as good bilaterally. There was no evidence of dermatomal deficits, and gross touch and pin prick were normal. The discussion and treatment plan included an MRI of the lumbar spine, possible epidural injections, continuation of psychotherapy, a gym membership, acupuncture, and he was given 2 packs of TENS unit pads. The psychiatric notes indicate that the patient has been having some anxiety. The patient also reported feeling depressed and having low energy and concentration, but no suicidal ideations. The patient reported some side effects from medication, like sexual; libido has decreased and he has decreased erection and delayed ejaculation. The patient had his Zoloft decreased to 50 mg by mouth daily for 2 weeks and then discontinued, and trazodone 100 mg at night as needed for insomnia. The patient was also started on Wellbutrin 150 mg daily for the depression. The patient reported problems with his 12-year-old son and wife. The patient's psychiatric diagnostic impression was depressive disorder, no otherwise specified, psychological factors affecting medic

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychotherapy x 12 visits: 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 Chronic Pain Medical Treatment Guidelines, Behavioral interventions Page(s): 23.

Decision rationale: CAMTUS recommends cognitive behavioral therapy. The guidelines state 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 Guidelines for chronic pain: screen 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 a cognitive motivational approach to physical medicine. The guidelines consider separate psychotherapy cognitive behavioral therapy referral after 4 weeks and lack of progress from physical medicine alone, an initial trial of 3 psychotherapy visits to 4 psychotherapy visits over 2 weeks, if there is evidence of objective functional improvement, a total of up to 6 visits to 7 visits over 5 weeks to 6 weeks. The clinical documentation submitted for review does not meet the guideline recommendations. The documentation submitted for review does not show evidence of objective functional improvement. Also, there is no documentation indicating a lack of progress from physical medicine alone. Given the lack of documentation to support guideline criteria, the request is non-certified.