

Case Number:	CM13-0013502		
Date Assigned:	03/19/2014	Date of Injury:	01/20/2005
Decision Date:	04/30/2014	UR Denial Date:	08/02/2013
Priority:	Standard	Application Received:	08/19/2013

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. The expert reviewer is Board Certified in Anesthesiology has a subspecialty in Pain Management and is licensed to practice in Florida. 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/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 58 year old female who reported an injury on 01/20/2005. The mechanism of injury was not stated. The patient is currently diagnosed with cervical spine disease and situational depression. The patient was seen by [REDACTED] on 08/08/2013. The patient reported ongoing cervical spine pain. Current medications included fentanyl, oxycodone, Ambien, Elavil, and Soma. Physical examination revealed severe myofasciitis, severe decreased range of motion, and radiation into bilateral upper extremities. Treatment recommendations included continuation of current medications. The patient was also seen by [REDACTED] on 09/04/2013 for a psychological evaluation for pain treatment. The patient reported persistent pain in the cervical spine and shoulder, as well as spasm and depression. The patient scored a 25 on the Beck Depression Inventory, indicating severe depression. The patient was diagnosed with depressive disorder. Treatment recommendations included supportive psychotherapy every other week for 8 weeks for depressive symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: This is a nonspecific request that does not include the specific dosage, frequency, or quantity. Therefore, the request is non-certified

SOMA: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: This is a nonspecific request that does not include the specific dosage, frequency, or quantity. Therefore, the request is non-certified.

8 CLINICAL PSYCHOLOGISTS VISITS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions.

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

Decision rationale: California MTUS Guidelines utilize ODG cognitive behavioral therapy guidelines for chronic pain, which allow for an initial trial of 3 to 4 psychotherapy visits over 2 weeks. While the patient does report depressive symptoms, the current request for 8 psychologist visits exceeds guideline recommendations. Therefore, the request is non-certified.