

Case Number:	CM13-0016310		
Date Assigned:	11/06/2013	Date of Injury:	08/20/2005
Decision Date:	03/12/2014	UR Denial Date:	08/16/2013
Priority:	Standard	Application Received:	08/26/2013

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 reviewer is licensed in Psychology and is licensed to practice in 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 47-year-old male who reported an injury on 08/20/2005 after the patient was crushed between a metal beam and a forklift, which resulted in a pelvic fracture, chronic pain in his lumbar spine and emotional distress. The patient's extensive treatment history has included surgical intervention, physical therapy, multiple medications, a spinal cord stimulator placement and psychiatric support. The patient's most recent clinical examination revealed that the patient had limited lumbar range of motion secondary to pain. It was documented that the patient had 4/10 to 5/10 pains with medications and 6/10 to 8/10 pain without medications. The patient's medications were listed to be ranitidine, piroxicam, Vesicare, OxyContin, Lyrica, Amitiza and Soma. The patient's diagnoses included arthropathy of the pelvis, chronic pain due to trauma, spondylosis of the lumbar spine, radiculopathy of the lumbar spine and degenerative disc disease of the lumbar spine. The patient's treatment plan included continued medications and cognitive behavioral therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive behavioral therapy - 13 sessions: Upheld

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

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

Decision rationale: The requested cognitive behavioral therapy for 13 sessions is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient previously received cognitive behavioral therapy. The California Medical Treatment Utilization Schedule recommends continued therapy based on objective functional gains. The clinical documentation submitted for review does not address any objective functional gains related to the previous therapy. Therefore, the need for additional therapy cannot be determined. As such, the requested cognitive behavioral therapy for 13 sessions is not medically necessary or appropriate.

Ativan 0.5mg #90: Upheld

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

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

Decision rationale: The requested Ativan 0.5 mg #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the extended use of this type of medication. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration of time. Additionally, the clinical documentation does not provide any evidence of functional improvement as a result of this medication. Therefore, continued use is not indicated. As such, the requested Ativan 0.5 mg #90 is not medically necessary or appropriate.

Prosom 2mg #90: Upheld

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

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

Decision rationale: The requested ProSom 2 mg #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the extended use of this type of medication. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration of time. Additionally, the clinical documentation does not provide any evidence of functional improvement as a result of this medication. Therefore, continued use is not indicated. As such, the requested ProSom 2 mg #90 is not medically necessary or appropriate.