

Case Number:	CM13-0032042		
Date Assigned:	12/04/2013	Date of Injury:	04/28/2012
Decision Date:	02/13/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	10/07/2013

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 Psychiatry, has a subspecialty in Neurology and is licensed to practice in California. 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 claimant is a 30 year old male who apparently slipped at work on 4/28/12, hitting his head, and sustained a traumatic brain injury and post-concussion syndrome. A request for continued CBT treatments, 12 bimonthly was made on 10/3/13. A Progress Report. Progress note dated 8/23/13 signed by [REDACTED] was submitted with the following information: "A videotelemetry test (EEG monitoring) did not indicate any day-time seizures but some type of night seizures... [REDACTED] prescribed citalopram, hydrocodone, Keppra and docusate sodium...Beck Inventory testing are suggestive of slight emotional disturbance...minimal range of clinical depression." The diagnosis given was "Cognitive Disorder secondary to a mild traumatic brain injury of 4/28/12." Other than videotelemetry, no observed, objective clinical findings were described to indicate a severe mental impairment or cognitive dysfunction in this report. A request for authorization dated 9/20/13 per [REDACTED] from [REDACTED] was reviewed. From a psychiatric perspective [REDACTED] indicated claimant's "Cognitive Status" was essentially unremarkable. No complete Mental Status exam was noted nor were there any mental complaints mentioned by the claimant. A 9/23/13 report from [REDACTED] indicates the claimant had no complaints of "significant depression or anxiety." None of the data available for my review had any current mental status finding or indication of functional improvement" during his course of mental health treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve sessions of Individual Psychotherapy bimonthly: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation California Medical Treatment Utilization Schedule, Sections: Functional Improvement

Decision rationale: Review of the records available indicates that there is insufficient objective clinical findings to support a severe mental disorder that would require additional Cognitive Behavioral Therapy. There was no mention as to the purpose of continued Cognitive Behavioral Therapy including for what mental disorder it was being requested. Cognitive Behavioral Stress Management (CBSM) was not mentioned nor supported by any objective clinical data. Nor was there any data regarding the functional status of the claimant from a psychiatric perspective. Such treatment at this time would not be medically necessary or medically appropriate. Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment."