

Case Number:	CM13-0037885		
Date Assigned:	12/18/2013	Date of Injury:	04/13/2007
Decision Date:	07/30/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	10/24/2013

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 Psychiatry, Neurology, and Addicton Medicine has a subspecialty in Geriatric Psychiatry and is licensed to practice in California 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 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:

Records reviewed include 244 pages of medical and administrative records. The injured worker is a 37 year old male with the diagnoses of pain in joint (lower leg), psychogenic pain NEC, major depression recurrent episode, and chronic pain syndrome with coping deficits and maladaptive health behaviors. His date of injury is 04/13/07 in which he fell into a trench and injured his right knee. He was evaluated by [REDACTED] psychologically on 08/01/11, and began cognitive behavioral therapy at that time. In a report dated 03/12/12 [REDACTED] indicated that the patient continued to have frequent low back and right knee pain, intermittent left knee pain, and constant neck tension and pain. The patient indicated that he was depressed, endorsing irritability, fatigue, lack of interest, and at that time suicidal ideation. A psychological exam on 05/03/13 notes that the patient's primary pain complaint was his left knee and neck, on average 7-8/10. The patient participated in a 6 week functional restoration program with psychological components between 5/20/13-07/03/13. He had completed 39 cognitive behavioral therapy sessions. On 08/09/13 the patient presented to [REDACTED] for pain management follow up with bilateral knee pain rated at 6/10. He was prescribed Capsaicin, Lidoderm patch, fluoxetine 40mg per day, Tramadol as needed, Protonix Sentra, Naproxen, and Glucosamine. He continued on a home exercise program. Records provided do not show any standardized scales with which to compare the patient's symptomatology at different points in his treatment. There are no further records of any psychological services provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 COGNITIVE BEHAVIORAL THERAPY FOLLOW UP VISITS WITH PSYCHOLOGIST [REDACTED]: Upheld

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

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

Decision rationale: According to CA-MTUS, behavioral interventions are recommended. 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. See also Multi-disciplinary pain programs. ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these at risk patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone:- Initial trial of 3-4 psychotherapy visits over 2 weeks- With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions). The patient had been in cognitive behavioral therapy since at least 2011. His chief complaint is knee pain, for which he is receiving pain management. He describes his average pain level as 7-8/10. He completed a functional restoration program, and has been deemed permanent and stationary. As he has received at the least 39 individual psychotherapy sessions, and ODG recommends a total of up to 6-10 visits over 5-6 weeks, he has surpassed the usual recommendations. In addition, there are no current records documenting the patient's subjective and objective symptomatology, and progress to date. As such this request is not medically necessary.