

<b>Case Number:</b>	CM13-0043952		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	08/04/2011
<b>Decision Date:</b>	04/24/2014	<b>UR Denial Date:</b>	10/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2013

### 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 Family Practice 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 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 37 year-old male who reported an injury on 08/14/2011. The mechanism of injury involved a fall. The patient is currently diagnosed with history of left frontal/left orbital skull fracture with ultra-consciousness, post concussive syndrome, cognitive dysfunction secondary to post concussive syndrome, left shoulder AC joint separation type 2, left wrist pain, status post left distal ulnar/radial comminuted fracture, low back pain, left ear keloid requiring surgical correction, chronic pain disorder associated with psychological factors and general medical condition, and medical disorders (nonindustrial). The patient was seen by [REDACTED] on 08/30/2013. The patient reports depression, anxiety, poor sleep quality and activity limitation. Physical examination on that date revealed 5/5 motor strength in bilateral upper extremities, intact sensation and muscle tone, slightly decreased cervical range of motion, and normal deep tendon reflexes. Treatment recommendations at that time included multidisciplinary pain management for analgesic medication, behavioral medicine, and functional restoration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **BEHAVIORAL MEDICINE TREATMENTS X 12 FOR EVALUATION AND TREATMENT OF AFFECTIVE/EMOTIONAL PAIN COMPONENT: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19-23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23. Decision based on Non-MTUS Citation (ODG), COGNITIVE BEHAVIORAL THERAPY

**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. Although the patient does report anxiety and depression, the current request for 12 sessions of behavioral medicine treatment exceeds guideline recommendations. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.