

Case Number:	CM13-0057152		
Date Assigned:	12/30/2013	Date of Injury:	08/31/2010
Decision Date:	05/06/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	11/25/2013

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 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 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 injured worker is a 58-year-old male with the date of injury of 08/31/2010. The injured worker was knocked unconscious but has not been able to return to work since in any capacity. The injured worker has a diagnoses of history of right facial fracture, multiple areas, complains of dizziness and blurry vision on the right side, posttraumatic stress disorder, depression secondary to chronic pain issues, and sleep issues. The initial date of request for psychotherapy was for 12 sessions and was dated 02/13/2013. There rational for identified patients during treatment of chronic pain. The request and rational for 6 cognitive behavioral therapy sessions was not provided for review. The injured worker had an MRI of the brain which was negative in 01/2011 and an EEG study was also negative. The patient had a negative sleep study although the quality of sleep study was poor due to disturbed sleep. The injured worker was seen on 07/17/2013 for a psychiatric follow-up visit. The physician notes that the injured worker seems to be doing better, more stable. It was noted the injured worker was taking medication as prescribed but still complaining of increased anxiety and irritability. The injured worker has no motivation or desire to do much and has lost interest in all pleasurable activities. The physician noted they will keep him on current medication of Depakote ER 500 mg 2 tabs at bedtime, Viibryd 40 mg at bedtime, and Latuda 40 mg at bedtime. The physician is requesting the injured worker to see a therapist for cognitive behavioral therapy. The injured worker was seen by primary care doctor on 08/14/2013 for a follow-up visit. The injured worker has complaints of facial pain and headaches. The injured worker notes that they did not like the decrease in Percocet to 3 a day, the medication is not lasting throughout the day. The injured worker notes that they continue to walk for exercise. Pain is noted at 8/10 and with medication it is 4/10. Current medications are Percocet 10/325 mg 3 times a day, Imitrex 40 mg as needed, Klonopin 0.5 mg twice daily, trazodone 50 mg 1 to 2 at night, Motrin 800 mg twice a day, Prilosec 20 mg

twice a day, and Deplin 15 mg at bedtime. The physician noted no significant changes on examination. On discussion/plan, the physician noted that they will be adding tramadol to see if this is helpful, prescription refills completed, continue with [REDACTED] and return in 1 month.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 COGNITIVE BEHAVIORAL THERAPY SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 400-401.

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

Decision rationale: CA MTUS/ACOEM Guidelines states the physician to screen for patients with risk factors for delayed recovery, including fear avoidance. Initial therapy should be physical medicine with a cognitive motivational approach. If there is a lack of progress for at least 4 weeks then consider psychotherapy. With evidence of objective functional improvement, the patient may have up to a total of 6-10 visits over 5-6 weeks. Per the 07/17/2013 evaluation that was submitted by [REDACTED], it was reported that the injured worker was doing better, more stable. The injured worker was taking medication as prescribed but still having increased anxiety and irritability. There was no diagnosis documented as part of this evaluation. The physician recommended the patient to continue the current medications and she would like him to be seen by a therapist for cognitive behavioral therapy. There was notation that he had seen a previous doctor for this; however, there was no documentation to report how many sessions the injured worker has already attended. There was no notation as far as if the therapy in the past had been helpful, also no documentation of any significant subjective, objective, or functional improvement with the injured worker. Due to lack of evidence of functional improvement resulting from past cognitive therapy, the request for 6 cognitive behavioral therapy sessions is non-certified.