

Case Number:	CM14-0018866		
Date Assigned:	04/23/2014	Date of Injury:	11/05/2003
Decision Date:	07/03/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/14/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 50-year-old female who reported an injury on 04/28/2010. The mechanism of injury was not specifically stated. The current diagnoses include chronic axial lumbosacral spine pain, axial cervical spine pain, left shoulder pain, bilateral upper extremity complaints, cervicogenic migraine headaches, mid trapezium and interscapular pain, and reactive depression with anxiety. The latest physician progress report submitted for this review is documented on 12/06/2013. The injured worker reported persistent pain in the cervical, thoracic and lumbar spine. It is noted that the injured worker was pending surgical intervention for hardware removal and sacroiliac joint (SI) joint fusion on the right. Previous conservative treatment was not mentioned. The physical examination revealed no apparent distress, a pleasant affect, diminished strength, positive impingement test on the left, positive tenderness at the acromioclavicular (AC) joint on the left, and decreased sensation to light touch in the SI dermatome, C6 and C8 dermatomes, and L5 dermatome. Treatment recommendations at that time included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

TWELVE (12) COGNITIVE BEHAVIOR THERAPY SESSIONS: Upheld

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

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

Decision rationale: The Chronic Pain Guidelines indicate that cognitive behavioral therapy is recommended. The guidelines utilize the Official Disability (ODG) Cognitive Behavioral Therapy Guidelines for chronic pain, which allow for an initial trial of three to four (3-4) psychotherapy visits over two (2) weeks. The injured worker does maintain a diagnosis of reactionary depression with anxiety; however, the current request for twelve (12) sessions of cognitive behavioral therapy exceeds the guideline recommendations. Therefore, the request is not medically necessary.

TWELVE (12) GROUP PSYCHOTHERAPY SESSIONS: Upheld

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

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

Decision rationale: The Chronic Pain Guidelines indicate that cognitive behavioral therapy is recommended. The guidelines utilize the Official Disability (ODG) Cognitive Behavioral Therapy Guidelines for chronic pain, which allow for an initial trial of three to four (3-4) psychotherapy visits over two (2) weeks. The injured worker does maintain a diagnosis of reactionary depression with anxiety; however, the current request for twelve (12) sessions of cognitive behavioral therapy exceeds the guideline recommendations. Therefore, the request is not medically necessary.

ONE (1) PRESCRIPTION OF CELEXA 10MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, MENTAL ILLNESS & STRESS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (SELECTIVE SEROTONIN REUPTAKE INHIBITORS) Page(s): 107.

Decision rationale: The Chronic Pain Guidelines indicate that selective serotonin reuptake inhibitors (SSRIs) are not recommended as a treatment for chronic pain, but may have a role in treating secondary depression. The current request does not include a frequency or quantity. Therefore, the request is not medically appropriate.

ONE (1) PRESCRIPTION LORAZEPAM 2MG: 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 Chronic Pain Guidelines indicate that benzodiazepines are not recommended for long term use because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit the use to four (4) weeks. There is no frequency or quantity listed in the current request. Therefore, the request is not medically necessary.