MAXIMUS Federal Services

Case Number:	CM14-0124836		
Date Assigned:	08/11/2014	Date of Injury:	04/05/2011
Decision Date:	09/24/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	08/07/2014

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 licensed in Psychology, has a subspecialty in Health Psychology and pain management 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 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:

According to the records that were provided for this independent review, this patient is a 31-year-old female who reported an industrial/occupational work injury on April 5, 2011. There are actually five dates of injury: 2005 left foot slipped on uncovered drain with turning and twisting of the knee and ankle; September 2010 slip and fall injury while carrying a 50 pound tray on left shoulder which landed on her left knee; 2011 walking past a walk-in fridge door the 30 pound case of wine on her shoulder the door hit the case of wine which she caught with her right arm after it hit her neck, head, face and pinning her against the left wall; and 2012 severe back spasm. And she reports pain to multiple body areas including right elbow, right shoulder and left knee. She is status post anterior ligament reconstruction. Spine area numbness and tingling and pain in the right shoulder, low back, right knee and ankle, stress, anxiety, depression. Medical diagnoses include right shoulder internal derangement, carpal tunnel syndrome, cervical spine herniated disc and multiple other problems that are documented elsewhere. A request was made for six sessions of group medical psychotherapy, the request was not approved; the utilization review rationale for non-certification of this request was stated that: there was no detailed discussion of the efficacy of prior treatment, that the injured worker is doing well and needs emotional support from the therapy that no new short or long-term goals were specified and that the patient has had 22 prior sessions with no new hard clinical Indicators for the need for additional treatment sessions provided. The patient had six visits of group medical psychotherapy certified on September 24, 2013 and another six sessions were certified on January 20, 2004. Six additional sessions appear to have been authorized on May 25, 2014 but this is somewhat unclear. Weekly sessions were attended in September and October 2013. Progress notes consisted of a stamp stating that patient participated in treatment with no details provided whatsoever. The QME

report states that the patient attended cognitive behavioral therapy from June 3, 2013 to September 9, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Group Medical Psychotherapy x6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Mental Illness and Stress.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines psychotherapy. Decision based on Non-MTUS Citation ODG, psychotherapy.

Decision rationale: The medical records consisted of primarily 400 pages of documents pertaining to treatment denials and requests for treatment. I was unable to find a single note from the treating psychologist regarding this patient. There were no progress notes from individual sessions, there were no treatment summaries provided there were no specific documents that indicated her psychological diagnosis, there was no treatment plans provided for this patient there was no results from any prior sessions that were provided either. According to the MTUS/ODG psychotherapy guidelines patients who are making progress in treatment may be offered a maximum of 13 to 20 sessions. Patients with severe symptomology in rare cases may be offered additional sessions up to 50 progress is being made. Additional sessions are contingent upon evidence of objective functional improvement derived from prior sessions and not solely based on the presence of psychological symptomology. There were no reports of the patient's progress from prior treatment sessions documented in the chart that I was given for this review. The only place I did find documentation of session attendance was a list of dates and a rubber stamp next to each state stating that the patient attended. There is a note from the utilization review stating that the patient has already had 22 sessions. It is unclear if the patient has had prior treatment episodes before this current one that were not included in that session total. Due to insufficient documentation of the actual prior treatment sessions and based on a utilization review noted notation the patient has already received more than the maximum allowed according to official disability guidelines, this request is not medically necessary and appropriate.