

Case Number:	CM14-0155412		
Date Assigned:	10/28/2014	Date of Injury:	07/15/2013
Decision Date:	12/04/2014	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	09/23/2014

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 Family Medicine 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:

This is a 54 year old male patient who sustained a work related injury on 7/15/13. Patient sustained the injury when he was picking up a rock about 100 pounds and he heard a loud pop in his low back. The current diagnoses include lumbar strain, degenerative disc disease, and myofascial pain syndrome. Per the doctor's note dated 9/22/14, patient has complaints of persistent back pain at 8-9/10. Physical examination revealed gait was normal, sensation was intact to light touch and pinprick bilaterally to the lower extremities, straight leg raise was negative, spasm and guarding in the lumbar spine and lumbar spine motor strength was 5/5 to hip flexion, hip extension, knee extension, knee flexion, ankle eversion, ankle inversion and extensor hallucis longus. The medication lists include Gabapentin, Nabumetone, Lunesta, Mirtazapine and Tramadol. The patient has had MRI of the low back that revealed some disc desiccation with mild central stenosis and mild neural foraminal stenosis on the right and electro-diagnostic testing and nerve conduction velocities of the bilateral lower extremities, which revealed right LS radiculopathy with active denervation. In October of 2013 and x-rays of the lumbar spine. Past surgical history includes cataract surgery in 2007 and surgery for varicose veins. The patient has had injection for this injury. The patient has received an unspecified number of PT visits for this injury. The patient was approved for a psychology consultation. Per the notes dated 11/22/13, the patient had psychological testing that revealed that he had depression and anxiety. Per the notes dated 12/27/13, the patient's mood and affect were appropriate. In the records dated 9/16/14, it was stated in the "impression" section that there was no evidence of significant depression and anxiety.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Sessions of cognitive behavioral therapy: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress; Cognitive behavioral therapy (CBT).

Decision rationale: ODG guidelines recommend an initial trial of 6 visits over 6 weeks and with evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions). The details of any psychotherapy done since the date of injury were not specified in the records provided. The requested additional visits in addition to the previously rendered psychotherapy visits sessions are more than recommended by the cited criteria. There was no evidence of significant ongoing progressive functional improvement from the previous psychotherapy visits that is documented in the records provided. The notes from the previous psychotherapy visits documenting significant progressive functional improvement were not specified in the records provided. Per the notes dated 11/22/13, the patient had psychological testing that revealed that he had depression and anxiety. Per the notes dated 12/27/13, the patient's mood and affect were appropriate. In the records dated 9/16/14, it was stated in the "impression" section that there was no evidence of significant depression and anxiety. A recent detailed psychological and behavioral evaluation note was not specified in the records provided. A recent behavioral cognitive therapy evaluation note was not included in the records provided. The medical necessity of the request for 6 sessions of cognitive behavioral therapy is not fully established in this patient.