

Case Number:	CM14-0169770		
Date Assigned:	10/17/2014	Date of Injury:	12/31/2009
Decision Date:	11/19/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/13/2014

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, has a subspecialty in Pain 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:

The injured worker is a 56 year-old male with a date of injury of December 31, 2009. The patient's industrially related diagnoses include degenerative disc disease of the lumbar spine, myalgia and myositis, and low back pain. The disputed issues are a request for a soft brace for the right knee and a request for psychology for individual therapy x 12 sessions. A utilization review determination on 10/7/2014 had non-certified these requests. The stated rationale for the denial of the soft brace was: "The medical records do not establish evidence of instability or internal derangement in the knee which would warrant bracing. Additionally, there is no indication that the patient will be stressing the knee under load. In fact, it is noted that the patient is not working." The stated rationale for the denial of physiological therapy was: "As the patient has already participated in previous psychotherapy, the medical records do not justify why the patient would require additional psychotherapy at this juncture. In fact, at the time of the most recent evaluation of August 18, 2014, there did not appear to be subjective complaints or objective findings consistent with a psychological diagnosis. Furthermore, the medical records do not establish clear functional improvement as a result of the previous psychological treatment."

IMR ISSUES, DECISIONS AND RATIONALES

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

Knee brace soft, right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Knee Brace

Decision rationale: ACOEM Chapter 13 "Knee Complaints" on page 340 states the following regarding knee bracing: "A brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability although its benefits may be more emotional (i.e., increasing the patient's confidence) than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary." Furthermore, Table 13-6 "Summary of Recommendations for Evaluating and Managing Knee Complaints" on page 346 classifies as optional "functional bracing as part of a rehabilitation program (D), and recommends against "prophylactic braces (D)" and "prolonged bracing for ACL deficient knee (D)." The Official Disability Guidelines also support the use of knee braces for knee instability, ligament insufficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful Unicompartmental osteoarthritis, and tibial plateau fracture. With regard to this injured worker, there is no documentation that he has any of the diagnoses for which a knee brace is indicated by the guidelines. The treating physician requested the soft brace for the right knee due to more pain with increased activity. However, patient is diagnosed with low back pain, myositis and myalgia, and degenerative disc disease of the lumbar spine. Additionally, in a medical evaluation report dated 6/9/2014, the treating physician documented that the injured worker "is using certain equipment to help in ambulation, namely, a cane and a brace specifically for walking." According to the documentation, the injured worker is already in possession of a knee brace and there is no further documentation as to why he requires an additional knee brace. Based on the guidelines and the documentation, the request for a soft brace for the right knee is not medically necessary.

Psychology for individual therapy x 12 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Medical Treatment Guidelines Psychological Treatment Page(s): 102.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state on page 102: "Psychological treatment: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and post-traumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective.

Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work." In the progress reports available for review, there is documentation that the injured worker was evaluated by a psychologist on 3/1/2013 and a psychiatrist on 7/9/2013. At that time, the psychiatrist documented that he was less sure than the psychologist that a course of psychotherapy would make a difference at that point in time. He further states: "However, up to 12 sessions of counseling including biofeedback and instruction in relaxation techniques as a means of pain management would be appropriate industrial care. Should the applicant opt to undergo surgery at some point in the future, an additional short course of outpatient counseling up to 1 dozen sessions should be provided." In a progress report dated 11/15/2013 there is documentation that the injured worker completed a multidisciplinary pain program. However, the reports available for review did not provide the dates that the injured worker attended the program or his response to the treatment. In the progress report dated 8/18/2014 at the time the psychological therapy was requested, there is very limited documentation on the injured worker's psychological state as it relates to his pain. The treating physician states that the injured worker had not received his Cymbalta and noticed the difference in his radicular pain, back pain, and his mood. There is no clear indication for psychotherapy since the psychiatrist recommended additional therapy under the condition that surgery is being considered. Based on the guidelines and available documentation, medical necessity cannot be established for the request of psychology for individual therapy x 12 sessions at this time.