

Case Number:	CM14-0173851		
Date Assigned:	10/27/2014	Date of Injury:	10/15/2010
Decision Date:	12/03/2014	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	10/21/2014

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 Practice and is licensed to practice in Ohio. 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 43-year-old male with reported date of injury of July 15, 2010. He complains of left knee pain radiating to the right knee and pain in the low back radiating to the left lower extremity. He has had two prior arthroscopic surgeries of the left knee but continues to have pain there nonetheless. He is being considered for another knee surgery. The physical exam reveals normal gait, diminished lumbar range of motion, and diminished light touch sensation to the left L4, L5, and S1 dermatomes. The range of motion of the left and right knee is limited. There is a positive patellar inhibition test on the left. The diagnoses include patellofemoral arthropathy, possible recurrent lateral meniscal tear, lumbar degenerative disc disease without myelopathy, and cervical radiculopathy. Injured worker is not taking any pain medications and has poor quality of sleep. He has returned to work. It is evident from the previous utilization review physician that on June 3, 2014 cognitive behavioral therapy and biofeedback sessions were recommended because it was felt that psychological stressors were interfering with recovery. Any notes from that day were not included for this review. Any notes pertaining to psychological issues were likewise not included for review. The sole note from the primary treatment provider comes from September 11, 2014. That note makes no mention of psychological issues but concludes with a statement that authorization for cognitive behavioral therapy is currently anticipated.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 Sessions of Cognitive Behavioral Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 24. Decision based on Non-MTUS Citation ODG, Cognitive Behavioral Therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Behavioral interventions CBT

Decision rationale: Cognitive behavioral therapy is recommended for those with chronic pain under certain conditions. Psychosocial variables have a potential role in delayed recovery and chronic pain. Risk Factors for delayed recovery include catastrophic thinking, fear-avoidance, and perceived injustice. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. Several recent reviews support the assertion of efficacy of cognitive-behavioral therapy (CBT) in the treatment of pain, especially chronic back pain (CBP). It is recommended that patients be screened for risk factors for delayed recovery, including fear avoidance beliefs. Initial therapy for these "at risk" patients should be physical therapy for exercise instruction, using a cognitive motivational approach to PT. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone. The CBT treatment model has three stages: (1) skill education (2) skill acquisition and (3) skill maintenance / generalization. Homework assignments are an essential part of CBT. When possible, CBT should be coordinated with physical therapy. There are no studies that delineate specific quantity and frequency of CBT sessions for chronic pain. Unfortunately, for purposes of this review, the previously referenced note from 6-3-2014 was not included. There was likewise no documentation available to support the notion that psychological factors were in any way impeding recovery. The injured worker was felt to have legitimate left knee issues with compensatory pain elsewhere. He was taking no pain medication and had returned to work. Therefore, the 4 Sessions of Cognitive Behavioral Therapy are not medically necessary.