

Case Number:	CM14-0030372		
Date Assigned:	06/20/2014	Date of Injury:	08/29/2008
Decision Date:	07/28/2014	UR Denial Date:	02/17/2014
Priority:	Standard	Application Received:	03/10/2014

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, and is licensed to practice in Texas. 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 41-year-old male who reported an injury on 08/29/2008 due to an unknown mechanism of injury. The injured worker complained of left shoulder pain rated 4/10, right shoulder pain rated 4/10, and lower back pain that radiated down his lower extremities, rated 8/10. On 01/22/2013, the MRI findings revealed impingement syndrome, mild anterior downsloping of the acromion process, mild subacromial bursitis, and mild to moderate osteoarthritis involving the acromioclavicular joint and mild tendinosis involving the footprint of the supraspinatus tendon anteriorly. The injured worker had a diagnosis of reactive depression, left shoulder impingement syndrome, and L5-S1 disc displacement with facet arthropathy. A past treatment method included left shoulder surgery on 09/20/2013. The injured worker was on the following medications: Omeprazole 20 mg, Norco 10/325 mg, Zanaflex 4 mg, and Restoril 30 mg. The current treatment plan is for psychotherapy 1 time a week x10 weeks. The rationale and request for authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Individual Psychotherapy 1xWk x 10Wks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request for individual psychotherapy 1xWk x 10 Wks is non-certified. The injured worker has a history of left and right shoulder pain, and low back pain radiating to his lower extremities. The California MTUS Guidelines state that psychotherapy therapy recommends an initial trial of 3 to 4 psychotherapy visits over 2 weeks. With evidence of objective functional improvement, total of up to 6 to 10 visits over 5 to 6 weeks (individual sessions). The documentation provided indicated that the injured worker did receive psychotherapy treatment prior to this request. However, there was no documentation of the injured worker's functional improvement. Guideline recommendations do not support extended treatment without documentation of exceptional factors. In addition, the request exceeds the recommended guidelines duration of treatment. Given the above, the request for individual psychotherapy 1 time a week x10 weeks is not medically necessary and appropriate.