MAXIMUS Federal Services

Case Number:	CM14-0062688		
Date Assigned:	07/11/2014	Date of Injury:	06/17/2011
Decision Date:	08/12/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	05/05/2014

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 70-year-old male who reported an unknown injury on 06/17/2011. On 04/25/2014, he was seen in a pain management clinic for a followup on his complaint of chronic low back pain. His diagnoses included lumbosacral spondylosis without myelopathy and degeneration of lumbar intervertebral discs. His past medical history included anxiety disorder, bronchitis, depression, GERD and high cholesterol. Medications included cyclobenzaprine 10mg, famotidine 40mg, Fluticasone 50mcg, ibuprofen 600mg, Levitra 10mg, penicillin V, potassium 500mg, Sildenafil 20mg, simvastatin 40mg, and vitamin D 50,000 units. His neurological examination revealed a normal mood and affect, oriented to time, place, and person, with intact recent and remote memory. A followup note of 05/23/2014 stated that the worker was doing remarkably well after completing his physical therapy. In addition, he had received authorization for home exercise equipment. Combining the worker's home exercise program with his access to exercise equipment enabled him to remain independent and reduce his pain symptoms. He described an increase in activity which included increased standing as well as walking time. He also reports better ability to socialize due to the decreased pain. He was planning on traveling to his home country for a 3 month visit. On a physical of 03/31/2014, it was noted that he had improved sleep tolerance since beginning therapy. A request for authorization dated 04/09/2014 was included in the documentation. There was no rationale included in the documents.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain psychology sessions (lumbar): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 101.

Decision rationale: Per the California MTUS, psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. Psychological interventions for chronic pain include setting goals, determining appropriateness of treatment, conceptualizing the patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing comorbid 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 treatments incorporated into pain management has been found to have a positive short term effect on pain interference and long term effect on returning to work. The documentation stated this worker was doing remarkably well after completing physical therapy and had begun a home exercise program. That allowed him to remain independent and reduce his pain symptoms. His activities which included standing and walking time, were increased. He also reported an increase in his socialization. He was planning a 3 month trip to his home country. He had a normal mood and affect and both long term and recent memory were intact. Although his history mentioned depression and anxiety disorder, he was not taking any antidepressant or anti-anxiety medications. There were no clinical data or psychometrics attesting to a diagnosis of depression or anxiety disorder. Therefore, this request for pain psychology sessions (lumbar) is non-certified.