

Case Number:	CM14-0074447		
Date Assigned:	07/16/2014	Date of Injury:	09/03/2002
Decision Date:	08/14/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/21/2014

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 Psychology 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 claimant is a 58 year-old female (██████████) with a date of injury of 9/3/02. The claimant sustained injury to her neck and back when she tried to hold her mother up after a heart attack. The claimant sustained this injury while working as a care giver for the ██████████. In his Primary Treating Physician's Progress/Periodic Report and Request for Referral/Treatment Authorization with Review of Records dated 6/13/14, ██████████ diagnosed the claimant with: (1) Possible disc herniation, cervical spine; (2) Status post right shoulder surgery; (3) Impingement syndrome, right shoulder; (4) Possible surgical changes versus new pathology, right shoulder; (5) Musculoligamentous sprain, lumbar spine; (6) 2 mm disc bulge/protrusion, L4-L5, L5-S1; (7) Spondylosis, lumbar spine; (8) Disc degeneration L1-2, L2-3, L3-4 & L4-5; and (9) Possible disc herniation, lumbar spine. Additionally, in his 6/25/14 Pain Medicine Re-evaluation, ██████████ diagnosed the claimant with: (1) Lumbar radiculopathy; (2) Right hip pain; (3) Right shoulder pain; (4) Anxiety; (5) Status post right shoulder surgery with residuals, treatment per future medical provisions. It is also reported that the claimant has developed psychiatric symptoms secondary to her work-related orthopedic injuries. In their 6/5/14 request for authorization, ██████████ and ██████████ diagnosed the claimant with: (1) Major depressive disorder; (2) Generalized anxiety disorder; and (3) Insomnia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive Behavioral Group Psychotherapy once a week times six (6) weeks: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision on the Official Disability Guidelines (ODG) Mental Illness and Stress Chapter.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) does not address the treatment of depression therefore, the Official Disability Guideline for the cognitive treatment of depression and the American Psychiatric Association (APA) Practice Guideline for the treatment of Patients with Major Depressive Disorder will be used as references for this case. Based on the review of the medical records, the claimant has been receiving psychiatric medication management from psychiatrist, [REDACTED] and psychological services from [REDACTED] and his colleagues. The number of completed individual, group, or hypnotherapy/relaxation sessions is unknown as the submitted documentation does not offer this information. Additionally, it is unclear as to how the claimant has been being treated by these providers. In the most recent Requested Progress Report dated 6/2/14, [REDACTED] and [REDACTED] indicate that the claimant appears responsive to treatment and is in need of continued treatment to address her symptoms. Her progress is listed as, the patient reports of increased motivation and attempts at social interactions with treatment and she utilizes cognitive restructuring exercises to help cope with current stressors. The treatment goals and the treatment plan are listed the same on all submitted reports. Lastly, the diagnosis is listed as, the patient's diagnosis remains unchanged. There is not enough information offered in the submitted progress reports to support additional services. As a result, the request for Cognitive Behavioral Group Psychotherapy once a week times six (6) weeks is not medically necessary.

Hypnotherapy/Relaxation Training Once a week times six (6) weeks: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. decision on the Official Disability Guidelines (ODG) Mental Illness and Stress Chapter Hypnosis.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) does not address the use of hypnotherapy therefore, the Official Disability Guideline regarding the use of hypnotherapy will be used as reference for this case. Based on the review of the medical records, the claimant has been receiving psychiatric medication management from psychiatrist, [REDACTED] and psychological services from [REDACTED] and his colleagues. The number of completed individual, group, or hypnotherapy/relaxation sessions is unknown as the submitted documentation does not offer this information. Additionally, it is unclear as to how the claimant has been being treated by these providers. In the most recent Requested Progress Report dated 6/2/14, [REDACTED] and [REDACTED] indicate that the claimant appears responsive to treatment and is in need of continued treatment to address her symptoms. Her progress is listed as, the patient reports of increased motivation and attempts at social interactions with treatment and she utilizes cognitive restructuring exercises to help cope with current stressors. The treatment goals and the treatment plan are listed the same on all submitted reports. Lastly, the diagnosis is listed as, the patient's diagnosis remains unchanged. There is not enough information offered in the submitted progress reports to support additional services. As a result, the request for Hypnotherapy/Relaxation Training Once a week times six (6) weeks is not medically necessary.

Office Visit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. decision on the Official Disability Guidelines (ODG) Mental Illness and Stress Chapter Office visits.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) does not address the use of office visits therefore, the Official Disability Guideline regarding office visits will be used as reference for this case. Based on the review of the medical records, the claimant has been receiving psychiatric medication management from psychiatrist, [REDACTED] and psychological services from [REDACTED] and his colleagues. The number of completed individual, group, or hypnotherapy/relaxation sessions in unknown as the submitted documentation does not offer this information. Additionally, it is unclear as to how the claimant has been being treated by these providers. In the most recent Requested Progress Report dated 6/2/14, [REDACTED] and [REDACTED] indicate that the claimant appears responsive to treatment and is in need of continued treatment to address her symptoms. Her progress is listed as, the patient reports of increased motivation and attempts at social interactions with treatment and she utilizes cognitive restructuring exercises to help cope with current stressors. The treatment goals and the treatment plan are listed the same on all submitted reports. Lastly, the diagnosis is listed as, the patient's diagnosis remains unchanged. There is not enough information offered in the submitted progress reports to support additional services. As a result, the request for Office visit is not medically necessary.