

Case Number:	CM14-0079057		
Date Assigned:	07/18/2014	Date of Injury:	07/20/2011
Decision Date:	10/08/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	05/29/2014

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 Utah. 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:

This is a 48-year-old female with a 7/20/2011 date of injury. The patient's psychiatric issues are due to work stressors and chronic pain. The patient was seen by a psychologist on 12/24/13 and had complaints of anxiety, depression, and impaired concentration. Findings on examination included anxiety, depression, and impaired concentration. The treatment plan was handwritten and illegible. Documentation also noted that the patient was most recently seen by a psychologist on 3/24/2014 with complaints of anhedonia, anxiety, depression, diminished energy, impaired concentration, impaired memory, irritability, sleep disturbance, chronic physical pain, and GERD. Exam findings revealed an anxious, depressed and tearful patient, with a Beck depression inventory score of 33 and a Beck anxiety inventory score of 43. It was noted that the patient was benefitting from treatment but slower than expected. The patient had diagnoses significant for major depression (single episode, moderate to severe, non-psychotic) and pain disorder associated with both psychological factors and a general medical condition, in addition to fibromyalgia, irritable bowel syndrome, lumbar disc disease, and other multiple orthopedic issues. In addition to the primary treating physician, the patient was also seen by a rheumatologist, psychologist, and psychiatrist. Her medications included gabapentin, topical flurbiprofen, tramadol, Trepadone, Sonata, non-steroidal anti-inflammatory drugs, Lyrica, Vicodin, Prilosec, Mobic, Xanax, Tylenol, Lidoderm patch, Levsin, and cyclobenzaprine. Treatment to date: medications, psychotherapy. An adverse determination was received on 5/12/2014. No rationale was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychotherapy 1 x Wk x 24Wks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Behavioral Intervention. Decision based on Non-MTUS Citation Official Disability Guidelines, Cognitive Behavioral Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 19-23.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that behavioral modifications are recommended for appropriately identified patients during treatment for chronic pain, to address psychological and cognitive function, and address co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). In addition, CA MTUS Chronic Pain Medical Treatment Guidelines state that with evidence of objective functional improvement, a total of up to 6-10 visits. The patient's psychotherapy progress notes were illegible and lacked sufficient documentation in regards to the number of psychotherapy sessions the patient has attended, and whether any functional gains were obtained from these sessions. The patient's Beck depression inventory (BDI) score of 33 and a Beck anxiety inventory (BAI) score of 43 were noted on the 3/24/2014 visit. No other BDI or BAI from other visits were noted for comparison. In addition, the UR determination allowed for 4 sessions of psychotherapy, which, in this case, is reasonable given the lack of documentation with regard to the patient's prior psychotherapy visits. Therefore, the request for Psychotherapy 1x week x 24 weeks as submitted are not medically necessary.