

Case Number:	CM14-0093167		
Date Assigned:	07/25/2014	Date of Injury:	10/09/2008
Decision Date:	08/28/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	06/19/2014

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 Clinical 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:

According to the medical records that were provided for this independent review, this patient is a 40 year old and 11 month male who reported an industrial/occupational work-related injury on October 9, 2008. The injury occurred reportedly when the side of dirt trench collapsed and fell on top of him while he was installing pipes for a draining system. His left knee was injured. He has ongoing knee pain and instability, history of lower back pain with lumbar degenerative joint disease non-industrial an industrial onset of depression, anxiety, and agitation. He has been diagnosed with Post-traumatic Stress Disorder, chronic; Major Depressive disorder, single episode, mild; and Anxiety disorder NOS (not otherwise specified). He has symptoms including: social withdrawal, diminished self-worth, restlessness, reduced Energy and libido, depressed mood, cheerfulness, irritability, and pessimism. A progress note from April 2014 from his treating psychologist specifies progress that has been made to date, Including: reducing his use of Cymbalta to 60 mg; decreasing Percocet from eight pills and eight down to two a day, His suicidal ideation has stopped. Additional functional improvements include fewer nightmares, fewer intrusive thoughts of the injury, taking better care of his appearance and hygiene, helping his wife with chores around the house, and improved control over his anger. Additional treatment his going to address his ability to confront stimuli related to his accident without becoming emotionally overwhelmed, Diminishing his use of analgesic medication, and helping him to further his progress and remain psychologically stable. A request was made for 4 additional psychotherapy sessions and was non-certified. The utilization review rationale for non-certification was that the total number of sessions to date the patient has received was included in the documentation provided, and that there is no treatment plan with the specific end date. This independent review will address a request to overturn that decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychotherapy 4x3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment. Decision based on Non-MTUS Citation ODG(Official Disability Guidelines)/TWC(treatment in workers compensation) Mental Illness & Stress Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part Two: Behavioral Interventions, Cognitive Behavioral Therapy Page(s): 23-24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, Psychotherapy Guidelines, June 2014 update.

Decision rationale: The patient has had substantial, and beneficial, psychological treatment over a period of time spanning at least 3 years. There are no psychological treatment notes prior to August 2012. A note from August 2012 states that it is an update, suggesting prior treatment was provided. He attended six sessions between August 2012 and November 2012 and he had 11 sessions between November 2012 and April 2013, he had 11 sessions between April 2013 and July 2013 and 7 sessions between November 25, 2013 and April 14, 2014. There is an indication that he may have had treatment prior to August 2012 but no records were provided. There is a block of time between July 2013 and November 2013 during which there are no records. I agree with the utilization review that, treatment plans do not contain goals that have dates by which they are expected to be achieved. According to the official disability guidelines ODG patients are allowed to have 13 to 20 visits of therapy in most cases, and in rare cases of severe major depression or PTSD additional sessions up to 50 can be provided. There is very good documentation that the patient has been making functional improvements as result of a psychological treatment, however these goals have been achieved quite some time ago from as best I can tell. It does appear this time that the patient has had an adequate course of psychological treatment and has probably had at least 34 sessions, but most likely has had more. At this juncture it appears that he has made substantial progress and that additional treatment at this time is not recommended as medically necessary.