MAXIMUS Federal Services

Case Number:	CM14-0200076		
Date Assigned:	12/10/2014	Date of Injury:	01/12/2008
Decision Date:	01/26/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	12/01/2014

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 Internal Medicine, 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 injured worker sustained a work related injury on January 12, 2008, to the cervical spine and lumbar spine. The exact mechanism of the work related injury was not provided. The injured worker was noted to have undergone cervical spine surgery on December 10, 2009, lumbar surgery on October 5, 2010, lumbar irrigation and debridement on October 29, 2010, and lumbar surgery on June 28, 2012. The surgical reports were not included in the documentation provided. The Primary Treating Physician's report dated March 24, 2014, noted the injured worker being treated for fibromyalgia, osteoporosis, chronic obstructive lung disease (COPD), anxiety, depression, and hypertension. The injured worker was noted to have entire body pain, and had developed gastric problems from the medications. An Agreed Medical Evaluator report dated July 30, 2014, noted the diagnoses as cervical sprain/strain, left C7 mild chronic radiculopathy per electromyography on April 17, 2013, lumbar sprain/strain, left lumbar radiculitis, lumbar myofascial pain, and chronic pain syndrome, in addition to the status post cervical and lumbar surgeries. A request for authorization was made for the transfer of care to [redacted] and/or cognitive behavior therapy (CBT) program.On October 30, 2014, Utilization Review evaluated the request for the transfer of care to [redacted] and/or cognitive behavior therapy (CBT) program, noting the MTUS American College of Occupational and Environmental Medicine (ACOEM) and the Official Disability Guidelines (ODG) were silent regarding the request. The UR Physician noted there was no documentation or rational for the need for cognitive behavior therapy (CBT) program, and no indication of the specialty of [redacted], thus there was not sufficient documentation for the transfer of care to [redacted] and/or cognitive behavior therapy (CBT) program, and the request was non-certified. The decision was subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transfer of care to [redacted] and/or a cognitive behavior therapy (CBP) program: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress, Cognitive Behavioral Therapy

Decision rationale: Pursuant to the Official Disability Guidelines, transfer of care to [redacted] and/or a cognitive behavior therapy (CBP) program is not medically necessary. The Official Disability Guidelines enumerated the frequency and duration of cognitive behavioral therapy (CBT). Up to 13 to 20 visits over 7 to 20 weeks (individual sessions), progress being made. The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued, if appropriate. Functional restoration programs include physical treatment, medical care and supervision, psychological and behavioral care, psychosocial care, and vocational rehabilitation and training and education. In this case, an Agreed Medical Evaluator saw the patient on July 30, 2014 (Pages ages 33- 39). The injured workers working diagnoses are left C7 mild chronic radiculopathy per EMG on April 17, 2013; left lumbar radiculitis; lumbar myofascial pain; and chronic pain syndrome.The reviewing physician felt "a more structured environment such as a functional restoration program would likely be required would be able to address the patient's condition more appropriately. It must be understood that prior to entering the functional restoration program certain requirements are necessary including a course of cognitive behavioral therapy". The guidelines do not require cognitive behavioral therapy prior to a Functional Restoration Program. Types of treatment within a functional restoration program may involve psychological and behavioral care, but there is no documentation indicating cognitive behavioral therapy is indicated. The AME physician believes an effective course of cognitive behavioral therapy is required prior to a functional restoration program. The guidelines do not support this approach. Consequently, absent the appropriate clinical indications and/or clinical rationale for cognitive behavioral therapy, transfer of care to [redacted] and/or a cognitive behavior therapy (CBP) program is not medically necessary.