

<b>Case Number:</b>	CM15-0003374		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	05/04/2001
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	12/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Texas

Certification(s)/Specialty: Psychiatry, Geriatric Psychiatry, Addiction Psychiatry

### 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 68 year old male, who sustained an industrial injury on 5/04/2001 when his left foot got caught in a conveyor belt. He has chronic pain in his low back and left leg. The diagnoses include complex regional pain syndrome of the left lower extremity; localized peripheral neuropathic pain over the area of internal pulse generator of spinal cord stimulator, altered gait, increased left knee pain, chronic neuropathic pain and opioid induced constipation. Treatment to date has included an implanted spinal cord stimulator (12/10/2002), for which the generator was replaced on 12/09/2014, medications and psychiatric evaluation and treatment. He currently complains of low back and left lower extremity pain. Objective findings include decreased lumbar spine range of motion and decreased sensation to light touch distally. His psychiatric diagnoses are depression NOS and psychological factors and general medical condition. He has symptoms of anxiety and depression. He had received CBT in 2003-2007 with benefit. There are supportive psychotherapy notes dating from 06/12/14 showing that the patient was seeing a therapist approximately every week, with the statement that he is "improving". On 12/16/2014, Utilization Review non-certified a request for individual psychotherapy once bi-weekly x 3 months, noting the lack of objective functional improvement with prior treatment. The MTUS was cited. On 12/16/2014, the injured worker submitted an application for IMR for review of individual psychotherapy once bi-weekly x 3 months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Individual Psychotherapy once bi-weekly times 3 months:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Recommended. The identification and reinforcement of coping skills is.

**Decision rationale:** The patient has been seeing a therapist since at least 06/12/14, with the general description of "improving". There are no more recent records to review beyond the UR of 12/16/14. There are no quantifiable scales (e.g. Beck Inventories) to demonstrate objective functional improvement. This request is therefore noncertified.