

Case Number:	CM15-0168162		
Date Assigned:	09/08/2015	Date of Injury:	05/23/2011
Decision Date:	10/07/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/26/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 44 year old man sustained an industrial injury on 5-23-2011. The mechanism of injury is not detailed. Diagnoses include headache status post craniotomy, cervical spine sprain-strain, right arm and leg numbness, dizziness, bilateral eye pain with conjunctivitis, adjustment disorder with mixed anxiety and depressed mood, bilateral temporomandibular joint, insomnia, and urinary incontinence. Treatment has included oral medications, rest, physiotherapy, orthopedist treatment, and psychological care. Physician notes dated 1-22-2015 show complaints of unchanged head pain rated 9.5 out of 10, eye pain rated 8 out of 10, right leg pain rated 7.5 out of 10 with tingling and lumps on the back of his leg, jaw pain rated 8.5 out of 10 with clicking and popping, difficulty falling asleep due to pain, dizziness, headaches, anxiety due to pain, and depression due to pain. Physical examination shows a stiff and tender neck, and decreased sensation in the right leg and arm. Recommendations include internal medicine consultation, psychiatric evaluation, follow up with temporomandibular joint specialist, stop Viscosetron, stop Citalopram, stop Fioricet, and follow up in four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psych for cognitive behavioral therapy evaluation & treatment 1 x 6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back Cognitive Behavioral Rehabilitation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive behavioral therapy (CBT) Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Cognitive behavioral therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, psych for cognitive behavioral therapy evaluation and treatment one time per week times six weeks is not medically necessary. Cognitive behavioral therapy guidelines for chronic pain include screening for patients with risk factors for delayed recovery including fear avoidance beliefs. Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after four weeks if lack of progress from physical medicine alone. Initial trial of 3 to 4 psychotherapy visits over two weeks. With evidence of objective improvement, up to 6 - 10 visits over 5 - 6 weeks (individual sessions). In this case, the injured worker's working diagnoses are headache status post right frontal craniectomy with protective overlying mesh material placement, hyperdensity of adjacent gyri with respect to surgical bed; spring strength cervical; numbness right arm, right leg; dizziness; bilateral eye pain with conjunctivitis; adjustment disorder with mixed anxiety and pressed mood; TMJ bilateral; insomnia, essential hypertension and urinary incontinence unspecified. Date of injury is May 23, 2011. There is no request for authorization in the medical record. The medical record contains 15 pages and one progress note by the non-requesting provider. The progress note documentation in the medical record dated January 22, 2015 subjectively states injured worker has no change in anxiety, depression, sleep, dizziness, head pain and musculoskeletal symptoms. There is no request the medical record for a psychological evaluation or cognitive behavioral therapy evaluation and treatment. Additionally, the guidelines recommend an initial trial of 3 to 4 psychotherapy visits over two weeks. The treating provider (not documented in the record) requested six psychotherapy cognitive behavioral therapy sessions. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no contemporaneous clinical documentation or any clinical documentation from the requesting provider, no clinical indication or rationale for cognitive behavioral therapy evaluation and treatment, psych for cognitive behavioral therapy evaluation and treatment one time per week times six weeks is not medically necessary.

Bilateral Sphenopalatine Ganglion block 2x5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Head - Sphenopalatine Ganglion (SPG) nerve block for headaches.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head section, Sphenopalatine Ganglion (SPG) nerve block for headache.

Decision rationale: Pursuant to the Official Disability Guidelines, bilateral sphenopalatine block 2xis not medically necessary. Sphenopalatine blocks are not recommended until there are higher quality studies. See guidelines for additional details. In this case, the injured worker's working diagnoses are headache status post right frontal craniectomy with protective overlying mesh material placement, hyperdensity of adjacent gyri with respect to surgical bed; spring strength cervical; numbness right arm, right leg; dizziness; bilateral eye pain with conjunctivitis; adjustment disorder with mixed anxiety and pressed mood; TMJ bilateral; insomnia, essential hypertension and urinary incontinence unspecified. Date of injury is May 23, 2011. There is no request for authorization in the medical record. The medical record contains 15 pages and one progress note by the non-requesting provider. The progress note documentation in the medical record dated January 22, 2015 subjectively states injured worker has no change in anxiety, depression, sleep, dizziness, head pain and musculoskeletal symptoms. Sphenopalatine blocks are not recommended until there are higher quality studies. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines and guideline non-recommendations for Sphenopalatine blocks, bilateral sphenopalatine block 2x5 is not medically necessary.