

<b>Case Number:</b>	CM15-0035515		
<b>Date Assigned:</b>	03/25/2015	<b>Date of Injury:</b>	06/30/2014
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2015

### 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

Certification(s)/Specialty: Family Practice

### 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 38 year old male, who sustained an industrial injury on 6/30/14. He has reported neck, back and right wrist due to a fall off a power pole approximately 7 feet down and landing on the top of the work truck. The diagnoses have included chronic low back pain, lumbar degenerative spondylosis, myofascial pain syndrome, pain disorder with psychological/general medical condition, insomnia due to pain, and degenerative cervical spondylosis. Treatment to date has included medications, physical therapy, activity modifications, Transcutaneous Electrical Nerve Stimulation (TENS) and diagnostics. Currently, as per the physician progress note dated 1/26/15, the injured worker presents with problems related to industrial injury. The right wrist and neck symptoms have improved significantly. The mid to low back continues to have pain and it is aggravated by certain movements such as bending forward. It was noted that he is back to work with a different company and there is no climbing. The current pain medication used is Lidoderm patches and Ibuprofen has been tried and failed. It was also noted that at the visit the association of chronic pain with emotional instability was discussed. The Treatment Plan included continue current medications for pain Lidoderm patches, urine drug screen performed, return to clinic in 1-2 months, and the requested treatments were Consultation with a behavioral medicine specialist (low back, pain disorder with psychological/general medical condition, insomnia, neck) and physical therapy times six sessions to include Transcutaneous Electrical Nerve Stimulation (TENS) unit trial. The work status was full duty as of 1/26/15.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Consultation with a behavioral medicine specialist (low back, pain disorder with psychological/general medical condition, insomnia, neck): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions and Psychological Evaluations Page(s): 23 & 100-101.

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

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of behavioral interventions as a treatment modality. A behavioral intervention is generally recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. As an example, the MTUS guidelines provide criteria for the use of Cognitive Behavioral Therapy as one of these interventions. For this providers should screen 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 4 weeks if lack of progress from physical medicine alone: Initial trial of 3-4 psychotherapy visits over 2 weeks. With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions). In this case, the primary issue is lack of specific documentation in the medical records as to the precise rationale for a behavioral intervention. The progress note dated 1/26/2015 appears to be the encounter, which generated the request for these services. However, there is no specific subjective information as to the nature of the patient's psychological issues. There is no content provided as to the symptoms the patient is experiencing. There is no content in the record as to an examination of the patient's mental state; to include use of standard assessment tools such as a PHQ-9 (patient health questionnaire). The 1/26/2015 encounter does state that the patient does not fulfill the criteria for major depressive disorder; however, it is not stated how this assessment was made. Further, the note indicates that patient is back to work at another job. In summary, there is insufficient information in the patient's history and examination to understand the rationale behind a request for a behavioral intervention. Given the lack of content in the record, a consultation with a behavioral medicine specialist (low back, pain disorder with psychological/general medical condition, insomnia) is not considered as medically necessary.