

<b>Case Number:</b>	CM15-0043040		
<b>Date Assigned:</b>	03/13/2015	<b>Date of Injury:</b>	01/28/2004
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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: Psychologist

### 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 62 year old male, who sustained an industrial injury on 01/28/2004. Initial complaints and diagnoses were not mentioned. Treatment to date has included conservative care/therapies, medications, injections, MRI of the lumbar spine (12/02/2014), and psychological/psychiatric evaluation. Currently, the injured worker complains of constant back pain with occasional radiation into the right lower extremity and occasional numbness and tingling in the right lower extremity. There was also noted complaints of depressed feelings. Diagnoses include low back pain. The treatment plan consisted of bilateral L4-L5 diagnostic facet injections, acetaminophen, and cognitive behavioral therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cognitive behavioral therapy QTY 8:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Behavioral Intervention Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines, Cognitive Behavioral Therapy.

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

**Decision rationale:** Based on the review of the medical records, the injured worker continues to struggle with chronic pain as a result of her work-related orthopedic injuries. It is noted within [REDACTED] reports that the injured worker completed a psychological evaluation with [REDACTED] in August 2014 and it was recommended that the injured worker receive 8 CBT sessions. Unfortunately, [REDACTED] report was not submitted for review. Without any information about the injured workers psychological functioning, diagnosis, and treatment recommendations, the need for subsequent psychotherapy cannot be fully determined. As a result, the request for 8 CBT sessions is not medically necessary. It is noted that the injured worker received a modified authorization for 4 CBT sessions in response to this request.