

<b>Case Number:</b>	CM15-0048321		
<b>Date Assigned:</b>	03/20/2015	<b>Date of Injury:</b>	05/01/2008
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2015

### 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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 69-year-old male, with a reported date of injury of 05/01/2008. The diagnoses include lumbar spinal stenosis at L4, lumbar disc displacement with lumbar radiculopathy, back strain, and degenerative disc disease at L4-5. Treatments to date have included oral medications and an MRI of the lumbar spine. Currently, the injured worker complains of low back pain that radiated down his legs. The progress report dated 02/17/2015 indicates that the injured worker rated his pain 6-7 out of 10. It was noted that the injured worker denied having a sense of great danger, anxiety, thoughts of suicide, mental problems, depression, thoughts of violence, or frightening visions or sounds. The objective findings include a lumbar spine without deformity; positive straight leg raise test with pain; and anger. The report indicates that the plan was for the injured worker to continue his prescribed psychotropic medication for his depressive symptoms. The treating physician requested psychiatry consultation and treatment, psychotherapy visits to prevent further psychological damage and to assist in pain control, podiatrist visit for toenail trimming due to inability to flex his back, TENS unit to help with pain control, and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Psychiatry consultation and treatment for medication: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, 2004, pg 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

**Decision rationale:** Technically, ACOEM Chapter 7 is not within the MTUS collection; therefore, it is more appropriately cited under the "Other Guidelines" categorization. ACOEM Guidelines, Chapter 7, Page 127, state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. In this case, the provider attests there are many denials. He denied having a sense of danger, anxiety, suicidal or homicidal ideation, depression, or thoughts of violence. The role then of a psychiatric consultant is not clear. Further, the request is ill-defined i.e. treatment for medicine. There is no mention of a frequency and duration, and what medicines may be needed. The request is not medically necessary.

**Psychotherapy visits, twice a month for 8 months: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines, Cognitive Behavioral Therapy for chronic pain.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental and Stress, under cognitive therapy.

**Decision rationale:** The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The ODG notes; Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. They suggest; Initial trial of 6 visits over 6 weeks. With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions). However, in this case, the provider attests there are many denials. He denied having a sense of danger, anxiety, suicidal or homicidal ideation, depression, or thoughts of violence. The role then for ongoing counseling is not clinically clear for injury care. The request is not medically necessary.

**Referral to podiatrist every two months: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, 2004, pg 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, Page 127.

**Decision rationale:** Technically, ACOEM Chapter 7 is not within the MTUS collection; therefore, it is more appropriately cited under the "Other Guidelines" categorization. ACOEM Guidelines, Chapter 7, Page 127, state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. The reason for referral to a podiatrist is simply to trim the toenails, per the records provided. This service does not require specialist care, and could be done by a spouse, friend, family or non-professional caregivers. The request is not medically necessary.

**TENS unit replaced with twelve month supply: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation Page(s): 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 116 of 127.

**Decision rationale:** The MTUS notes that TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. Neuropathic pain: Some evidence (Chong, 2003), including diabetic neuropathy (Spruce, 2002) and post-herpetic neuralgia. (Niv, 2005) Phantom limb pain and CRPS II: Some evidence to support use. (Finsen, 1988) (Lundeberg, 1985) Spasticity: TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. (Aydin, 2005) Multiple sclerosis (MS): While TENS does not appear to be effective in reducing spasticity in MS patients it may be useful in treating MS patients with pain and muscle spasm. (Miller, 2007) I did not find in these records that the claimant had these conditions that warranted TENS. Also, an outright purchase is not supported, but a monitored one month trial, to insure there is objective, functional improvement. In the trial, there must be documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. There was no evidence of such in these records. The request is not medically necessary.

**Physical Therapy, twice a week for three weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98 of 127.

**Decision rationale:** The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. In addition, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. In addition, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cited: 1. Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. 2. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self-actualization. This request for more skilled, monitored therapy was not medically necessary.