

Case Number:	CM14-0216048		
Date Assigned:	01/06/2015	Date of Injury:	07/27/2009
Decision Date:	02/24/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/23/2014

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:

This 55 year old male sustained a work related injury on 07/27/2009. The mechanism of injury was not made known. According to a progress note dated 11/20/2014, the provider noted back pain and left hand pain. The medication regimen included Lidocaine patch, Norco, Gabapentin, Zipsor, Nortriptyline, Pristiq and Voltaren Gel 1%. Diagnoses included cervical spondylosis, myelopathy and cervicgia. According to a patient questionnaire, the injured worker was sleeping 3 hours per night and eating 2 meals per day and one snack. He was not making his own meals. He was independent with bathing, dressing and toileting. His emotional well- being remained the same. Pain was rated a 9 on average on a scale of 0-10. Pain was rated a 7 with medications and a 10 without medications. He exercised 6 times a week for 30 minutes in the form of walking. The injured worker brought in recommendations that were made by another provider an included psychotherapy, med management and temporary total disability. A referral was made and included the diagnosis of depression post injury. There was no documentation submitted for review by the provider who made these recommendations. On 12/01/2014, Utilization Review non-certified 16 sessions of psychotherapy that was requested on 11/20/2014. According to the Utilization Review physician, psychotherapy is generally recommended in chronic pain patients if need. The recommendation was made by another physician from whom there was no actual documentation provided. The injured worker will be approved to see a psychiatrist (named in the Utilization Review) regarding psychiatric needs. It would seem appropriate that he make any recommendations for further psychotherapy interventions as needed. Guidelines referenced for this review included CA MTUS Chronic Pain Medical

Treatment Guidelines Psychological Treatment and the Official Disability Guidelines Cognitive Behavioral Therapy. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

16 sessions of psychotherapy with treating physician: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 101-102 & 23.

Decision rationale: Per guidelines: "Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following stepped-care approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. See also ODG Cognitive Behavioral Therapy (CBT) Guidelines. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005) Behavioral interventions (Chronic Pain Medical Treatment Guidelines, CA MTUS 2009) (page 23) 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. See also Multi-disciplinary pain programs. ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). 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)." The request for psychotherapy was made by treating physician and was based upon recommendations from an undated psychological evaluation. Unfortunately, the physician's

evaluation report nor any other psychological medical records were included for review. Without any information to substantiate the need for psychological services, the need for services cannot be determined and the request for psychotherapy is not reasonable.