

Case Number:	CM15-0010289		
Date Assigned:	01/27/2015	Date of Injury:	05/30/2007
Decision Date:	03/17/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	01/18/2015

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:

The injured worker is a 45-year-old male, with a reported date of injury of 05/30/2007. The diagnoses include severe major depression, generalized anxiety disorder, and provisional panic disorder. Treatments have included psychological treatment, antidepressant medication, and cognitive behavioral therapy. The behavioral medicine report dated 12/01/2014 indicates that the injured worker noticed a big improvement since he started the behavioral medicine services sessions. He had increased his interaction with family members. His family gave him feedback on how much he changed and looked more energetic. The injured worker felt more motivated. The objective findings showed that the injured worker looked very enthusiastic/energetic, was smiling more while talking about an idea he had. The treating provider requested pain management counseling six times a week for six weeks, because the injured worker expressed that he wished to have more sessions because the behavioral medicine services sessions helped him cope better with his pain. On 01/09/2015, Utilization Review (UR) modified the request for thirty-six (36) sessions of pain management counseling. The UR physician noted that there was documentation of the injured worker's improvements, and the guidelines indicate that a total of ten visits of cognitive behavioral therapy may be appropriate if there was evidence of functional improvement during the initial trial. The UR physician certified six (6) sessions of pain management counseling. The MTUS Chronic Pain Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

36 Sessions of Pain Management Counseling: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive Behavioral Therapy (CBT). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cognitive Behavioral Therapy (CBT)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive behavioral therapy Page(s): 23. Decision based on Non-MTUS Citation Mental illness and stress, Cognitive behavioral therapy; Pain section, Office visits

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, 36 sessions pain management counseling is not medically necessary. The need for a clinical office visit with a healthcare provider is individualized based upon review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking since some medications such as opiates or medicines such as certain antibiotics require close monitoring. The identification and reinforcement of coping skills is more often useful in the treatment of pain and ongoing medicine or therapy, which could lead to psychological and/or physical dependence. The guidelines for cognitive behavioral therapy include, but are not limited to, the 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 cognitive behavioral therapy (CBT) after four weeks if lack of progress from physical medicine alone. An initial trial of 3-4 psychotherapy visits over two weeks; with evidence of objective functional improvement total of up to 6 to 10 visits over 5 to 6 weeks may be indicated. In this case, the injured worker's working diagnoses are lumbago; major depressive disorder, single episode, severe; and panic disorder. Subjectively, there were no complaints documented. Objectively, the injured worker looks very enthusiastic and energetic and smiling more while he was talking about prospective job opportunity. There were no objective findings in the medical record. There was a behavioral medicine report dated December 1, 2014 from session 4/4. The progress summary stated the injured worker has noticed a big improvement since he started the behavioral medicine services sessions. He has increased his interaction with family members. He is working on his tendency to isolate himself. The treating physician requested 36 sessions of pain management counseling. The guidelines recommend an initial trial of 3-4 psychotherapy visits over two weeks. With evidence of objective functional improvement a total of 6 to 10 visits over 5 to 6 weeks may be indicated. The request for 36 sessions exceeds the recommended guidelines. Additionally, according to the Official Disability Guidelines, the need for clinical office visit with healthcare providers individualize based on patient concerns, signs and symptoms and reasonable physician judgment. There is no clinical indication/rationale for 36 sessions without intermittent physician follow-up to determine an ongoing clinical need. Additionally, there were no subjective and objective findings documented in the medical record reflecting an ongoing need for 36 additional sessions. Consequently, absent clinical documentation setting forth a clinical need for ongoing pain management counseling (36 sessions) according to the recommended guidelines, 36 sessions pain management counseling is not medically necessary.