

Case Number:	CM15-0122461		
Date Assigned:	07/06/2015	Date of Injury:	09/04/2014
Decision Date:	07/31/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	06/25/2015

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: North Carolina

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 50-year-old male, who sustained an industrial injury on 9/4/14. He has reported initial complaints of a low back injury. The diagnoses have included low back pain, left lower extremity (LLE) radiculopathy, myofascial pain syndrome, sleep disorder and depression. Treatment to date has included medications, activity modifications, injection, and physical therapy. Currently, as per the physician progress note dated 2/10/15, the injured worker complains of low back pain with spasms and problems with sleeping and depression. The physical exam reveals that he is in pain with grimacing and sitting with a rigid posture. He appears uncomfortable and shifts positions. His mood is dysthymic and he looks like he has not slept in some time. His thought process is goal directed and insight is fair. The gait is antalgic with most of his weight on the right side and circumducting on the left. The lumbar range of motion is decreased with pain. There is weakness on the left compared to the right with difficulty with heel lifts on the left. There is decreased sensation to light touch and pinch on the S1 distribution. There are no previous diagnostic reports noted. There is a few physical therapy sessions noted. The physician requested treatment included 8 office visits with a psychologist for psychological treatment as the injured worker has significant evolving depression.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 office visits with a psychologist for psychological treatment: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Behavioral interventions. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cognitive Behavioral Therapy (CBT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines psychotherapy Page(s): 101-102.

Decision rationale: The California chronic pain medical treatment guidelines section on psychological treatment states: 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) Psychological treatment in particular cognitive behavioral therapy has been found to be particularly effective in the treatment of chronic pain. As this patient has continued ongoing pain as well as mood disorder, this service is indicated per the California MTUS and thus is medically necessary.