

Case Number:	CM15-0096440		
Date Assigned:	05/26/2015	Date of Injury:	02/13/2001
Decision Date:	06/30/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/19/2015

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:

This is a 73-year-old male with a February 13, 2001 date of injury. A progress note dated April 21, 2015 documents subjective findings (activity continues to be very limited and motivation is poor; neck pain; bilateral knee pain; lumbar pain; left elbow and wrist pain; pain rated at a level of 6/10 at best and 9/10 at worst), objective findings (right paracervical tenderness; decreased range of motion of the cervical spine; bilateral lumbar tenderness; decreased range of motion of the lumbar spine; weak and antalgic gait; bilateral lumbar spasms; decreased strength of the right lower extremity with notable atrophy compared to the left lower extremity; decreased sensation to pin at right L4, L5 and S1; decreased distal right ulnar nerve), and current diagnoses (shoulder impingement syndrome; carpal tunnel syndrome; cervical radiculopathy; cubital tunnel syndrome; right foot drop; sprain/strain of the lumbar region; lumbar facet arthropathy; failed back surgery syndrome). Treatments to date have included physical therapy, medications, and back surgery. The treating physician documented a plan of care that included additional psychological follow up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional psychologist follow up visits x 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part Two, Behavioral Interventions, Psychological Treatment; see also ODG Cognitive Behavioral Therapy Guidelines for Chronic Pain. Pages 101-102; 23-24. Decision based on Non-MTUS Citation ODG: Chapter Mental Illness and Stress, Topic: Cognitive Behavioral Therapy, Psychotherapy Guidelines March 2015 update.

Decision rationale: According to the MTUS treatment guidelines, psychological treatment is 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 functioning, and addressing comorbid mood disorders such as depression, anxiety, panic disorder, and PTSD. The identification and reinforcement of coping skills is often more useful in the treatment of chronic pain and ongoing medication or therapy which could lead to psychological or physical dependence. An initial treatment trial is recommended consisting of 3-4 sessions to determine if the patient responds with evidence of measurable/objective functional improvements. Guidance for additional sessions is a total of up to 6-10 visits over a 5 to 6 week period of individual sessions. The official disability guidelines (ODG) allow a more extended treatment. According to the ODG studies show that a 4 to 6 sessions trial should be sufficient to provide symptom improvement but functioning and quality- of-life indices do not change as markedly within a short duration of psychotherapy as do symptom-based outcome measures. ODG psychotherapy guidelines: up to 13-20 visits over a 7-20 weeks (individual sessions) if progress is being made. The provider should evaluate symptom improvement during the process so that treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate. In some cases of Severe Major Depression or PTSD up to 50 sessions, if progress is being made. A request was made for additional psychologist follow-up visits x 6; the request was noncertified by utilization review with the following rationale provided: open psychological treatment is not satisfied. In particular, there is no documentation of improved mental health with prior psychological care. In addition there are no objective findings to support the request." This IMR will address a request to overturn the utilization review decision. The medical records which were provided for this review were very limited and consisted of only a few pages. According to an April 22, 2015 treatment progress note from the primary physician the patient has complaints "of depression, memory loss. But denies mental disturbance, suicidal ideation summations or paranoia."Continued psychological treatment is contingent upon the establishment of the medical necessity of the request. This can be accomplished with the documentation of all of the following: patient psychological symptomology at a clinically significant level, total quantity of sessions requested combined with total quantity of prior treatment sessions received consistent with MTUS/ODG guidelines, and evidence of patient benefit from prior treatment session including objectively measured functional improvement. In this case, the medical necessity the requested treatment is not established by the limited documentation provided for review. Specifically, there is no psychological treatment progress notes from prior treatment. Is not clear how much treatment the patient is had to date in terms of session quantity or duration. Because no treatment progress notes were provided it could not be determined if the patient has derived benefit from prior psychological treatment. There is virtually no description of the patient's current psychological status other than the above mentioned brief note from his primary treating physician. No treatment plan could be found was stated goals and estimated dates of accomplishment. Because there was virtually no documentation regarding the patient's prior psychological treatment, the medical necessity of this request was not established in the

utilization review determination of non-certification is upheld. The request is not medically necessary.