

<b>Case Number:</b>	CM13-0011731		
<b>Date Assigned:</b>	09/30/2013	<b>Date of Injury:</b>	02/06/2004
<b>Decision Date:</b>	01/23/2014	<b>UR Denial Date:</b>	08/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Psychiatry, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 case involves a seventy year old female Electrician injured 02-06-2004. She has been diagnosed with Major depressive disorder, moderate, industrial. Pain disorder associated with medical condition, chronic pain and loss of vision, industrial. Levels II sleep disorder. She has also had urinary stress incontinence and partial fecal incontinence. Her gait has been noted to be unsteady. She walks with a cane and can only walk two blocks. She has been treated with various medications including: Ativan, Zoloft, acyclovir, Aciphex, Buspar, Ambien, Norco, Prozac, Cymbalta, Wellbutrin, Effexor, Remeron, aspirin, multivitamin. (Not all at the same time) Under review are medication management, psychotherapy, group therapy, hypnotherapy, biofeedback and nutritional counseling.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Individual psychotherapy(cognitive/behavioral therapy) X 12:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Treatment guidelines and ODG

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26, page 23 has the following to state about Behavioral interventions: "Recommended. 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)" These guidelines are clear that a total of up to 6-10 visits are in keeping with guidelines. With respect to PTSD, the records contain mixed information about PTSD. The phrase "PTSD" appears often in the records, and was the subject of discussion amongst clinicians. The consensus seems to be that the patient had a great deal of anxiety and a great deal of trauma in her life. Several of the clinicians discussed PTSD as a possible diagnosis but it is not part of her official consensus diagnosis. Although 12 psychotherapy sessions exceeds that guideline of 6-10 sessions, there was a great deal of material in the record indicating this elderly patient may have had symptoms on a spectrum near the formal diagnosis of PTSD. The MTUS guidelines allow a great deal of extra psychotherapy for patients with PTSD. Given this patient's clinical picture, and given the guidelines massive extra allowance in psychotherapy sessions for PTSD patients, it is my opinion that 12 psychotherapy sessions are medically necessary for this patient.

**Treatment with psychiatrist for medication management x 12: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Treatment guidelines and ODG

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 27, 107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, office visits; American Psychiatric Association Practice Guidelines Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition

**Decision rationale:** The CA MTUS does not specifically address office visits for psychiatric medication management. The ODG does address office visits as follows: ODG, Mental Illness & Stress, and Office Visits. Recommended as determined to be medically necessary; Evaluation and ,management (E&M) outpatient visits to the Offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The American Psychiatric Association Practice Guidelines Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition DOI: 10.1176/appi.books.9780890423387.654001 states the following with respect to therapeutic interventions: "b. Assessing the adequacy of treatment response In assessing the adequacy of a therapeutic intervention, it is important to establish that treatment has been administered for a sufficient duration and at a sufficient frequency or, in the case of medication, dose [I]. Onset of benefit from psychotherapy tends to be a bit more gradual than that from medication, but no

treatment should continue unmodified if there has been no symptomatic improvement after 1 month [I]. Generally, 4-8 weeks of treatment are needed before concluding that a patient is partially responsive or unresponsive to a specific intervention [II]." This reviewer notes that National standards of care require that the patient receives a minimum of eight medication management sessions over a twelve month period in order to assess the efficacy of the medications such as Ativan, Zoloft, acyclovir, Aciphex, Buspar, Ambien, Norco, Prozac, Cymbalta, Wellbutrin, Effexor, Remeron and aspirin. Not only does this patient need two medication management visits with a psychiatrist but will need ongoing psychiatric medication management visits with a psychiatrist over time for many reasons including but not limited to monitoring the patient for safety, efficacy of medications and monitoring for adverse effects such as increased suicidal ideation. Frequent visits would be needed to assess the patient's safety, overall condition and to monitor lab tests. In addition, the prescriber would need to collaborate with the entire health care team. In the specific case of this patient, she had a large amount of psychiatric medication management records available from [REDACTED]. Though the patient was difficult to treat, [REDACTED] records were clear, thorough and documented clear evidence of sound psychiatric medication management with clear evidence of optimized outcome as a result of effective care. As such, and with the support of the guidelines cited above, twelve medication management sessions with a psychiatrist are medically necessary.

#### **Pain management group therapy x 12: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Treatment guidelines and ODG

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26, page 23 has the following to state about Behavioral interventions: "Recommended. 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)" These guidelines are clear that a total of up to 6-10 visits are in keeping with guidelines. With respect to PTSD, the records contain mixed information about PTSD. The phrase "PTSD" appears often in the records, and was the subject of discussion amongst clinicians. The consensus seems to be that the patient had a great deal of anxiety and a great deal of trauma in her life. Several of the clinicians discussed PTSD as a Although 12 group psychotherapy sessions exceeds that guideline of 6-10 sessions, there was a great deal of material in the record indicating this elderly patient may have had symptoms on a spectrum near the formal diagnosis of PTSD. The MTUS guidelines allow a great deal of extra psychotherapy for

patients with PTSD. Given this patient's clinical picture, and given the guidelines massive extra allowance in psychotherapy sessions for PTSD patients, it is my opinion that 12 group psychotherapy sessions are medically necessary for this patient. Possible diagnosis but it is not part of her official consensus diagnosis.

### **Hypnotherapy weekly x 12: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Treatment guidelines and ODG

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Integrated Treatment/Disability Duration Guidelines Mental Illness & Stress Chapter

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment Guidelines were silent on hypnotherapy. The Official Disability Guidelines, ODG -TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines Mental Illness & Stress Chapter States the following on Hypnosis: "Recommended as an option, as indicated below. Hypnosis is a therapeutic intervention that may be an effective adjunctive procedure in the treatment of Post-traumatic stress disorder (PTSD), and hypnosis may be used to alleviate PTSD symptoms, such as pain, anxiety, dissociation and nightmares, for which hypnosis has been successfully used. (VA/DoD, 2004)(Brom, 1989) (Sherman, 1998) In a study testing the effect of hypnosis on irritable bowel syndrome (IBS), it was found that the hypnosis was effective in reducing psychological distress and as a result, the IBS symptoms improved substantially, despite there being no measured physiological change. More testing should be done to measure the effect of hypnosis on stress reduction, with or without physical ailment, as preliminary results are positive. (Palsson, 2002) According to one meta-analysis, hypnotherapy is highly effective for patients with refractory IBS, but definite efficacy of hypnosis in the treatment of IBS remain unclear (Gholamrezaei, 2006) Hypnosis is not a therapy per se, but an adjunct to psychodynamic, cognitive-behavioral, or other therapies, and has been shown to enhance significantly their efficacy for a variety of clinical conditions. In the specific context of post-traumatic symptomatology, hypnotic techniques have been used for the psychological treatment of shell shock, battle fatigue, traumatic neuroses, and more recently, PTSD, and dissociative symptomatology. Hypnosis is defined by the APA as "a procedure during which a health professional or researcher suggests that a client, patient, or subject experience changes in sensations, perceptions, thought, or behavior." The hypnotic context is generally established by an induction procedure. An induction procedure typically entails instructions to disregard extraneous concerns and focus on the experiences and behaviors that the therapist suggests or that may arise spontaneously. Most of the case studies that reported that hypnosis were useful in treating post-trauma disturbances following a variety of traumas lack methodological rigor, and therefore strong conclusions about the efficacy of hypnosis to treat PTSD cannot be drawn. Various meta-analyses of studies on the treatment of anxiety, pain, and other conditions imply that hypnosis can substantially enhance the effectiveness of psychodynamic and CBTs; however, most of the literature on the use of hypnosis for PTSD is based on service and case studies. Hypnotic techniques have been reported to be effective for symptoms often associated with PTSD such as pain, anxiety and repetitive

nightmares. (VA/DoD, 2004)" Since hypnosis has been noted to help some patients with PTSD, and since this patient had a great deal of anxiety

**Biofeedback x 12: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Treatment guidelines and ODG

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 24-25.

**Decision rationale:** The CA MTUS 8 C.C.R. Â§Â§9792.20 - 9792.26 sets forth the following guidelines on biofeedback on pages 24 and 25: "Not recommended as a stand-alone treatment, but recommended as an option in a cognitive behavioral therapy (CBT) program to facilitate exercise therapy and return to activity. There is fairly good evidence that biofeedback helps in back muscle strengthening, but evidence is insufficient to demonstrate the effectiveness of biofeedback for treatment of chronic pain. Biofeedback may be approved if it facilitates entry into a CBT treatment program, where there is strong evidence of success. As with yoga, since outcomes from biofeedback are very dependent on the highly motivated self-disciplined patient, we recommend approval only when requested by such a patient, but not adoption for use by any patient. EMG biofeedback may be used as part of a behavioral treatment program, with the assumption that the ability to reduce muscle tension will be improved through feedback of data regarding degree of muscle tension to the subject. The potential benefits of biofeedback include pain reduction because the patient may gain a feeling that he is in control and pain is a manageable symptom. Biofeedback techniques are likely to use Surface EMG feedback so the patient learns to control the degree of muscle contraction. The available evidence does not clearly show whether biofeedback's effects exceed nonspecific placebo effects. It is also unclear whether biofeedback adds to the effectiveness of relaxation training alone. The application of biofeedback to patients with CRPS is not well researched. However, based on CRPS symptomology, temperature or skin conductance feedback modalities may be of particular interest. (Keefe, 1981) (Nouwen, 1983) (Bush, 1985) (Croce, 1986) (Stuckey, 1986) (Asfour, 1990) (Altmaier, 1992) (Flor, 1993) (Newton-John, 1995) (Spence, 1995) (Vlaeyen, 1995) (NIH-JAMA, 1996) (van Tulder, 1997) (Buckelew, 1998) (Hasenbring, 1999) (Dursun, 2001) (Van Santen, 2002) (Astin, 2002) (State, 2002) (BlueCross BlueShield, 2004) This recent report on 11 chronic whiplash patients found that, after 4 weeks of myofeedback training, there was a trend for decreased disability in 36% of the patients. The authors recommended a randomized-controlled trial to further explore the effects of Myofeedback training. (Voerman, 2006). See also cognitive behavioral therapy (Psychological treatment) ODG biofeedback therapy guidelines: Screen for patients with risk factors for delayed recovery, as well as motivation to comply with a treatment regimen that requires self-discipline. Initial therapy for these "at risk" patients should be physical medicine exercise instruction, using a cognitive motivational approach to PT. Possibly consider biofeedback referral in conjunction with CBT after 4 weeks: 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 sessi

**Nutritional group counseling program 90 min/session x 12: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Treatment guidelines and ODG

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); American Dietetic Association site and National Clearinghouse for treatment guidelines

**Decision rationale:** The CA MTUS CPMTG, ODG and ACOEM were silent on nutritional group counseling in the context of pain and depression. The American Dietetic Association site and even the national clearinghouse for treatment guidelines were silent on nutritional group counseling in the context of pain and depression. The patient seemed to benefit from the nutritional groups and had many medical problems that seemed as though they would benefit from dietary optimization. All of that having been said, this reviewer was unable to locate guidelines that would support the use of ongoing regular lengthy nutrition counseling groups. As a result of this apparent void in the guidelines, the nutritional group counseling is not medically necessary in the quantity requested.