

Case Number:	CM13-0023192		
Date Assigned:	11/15/2013	Date of Injury:	04/06/2009
Decision Date:	01/13/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/11/2013

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.

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 57 year old female that on 04/06/09 she "blacked out" at work. She fell on a concrete surface and when she regained consciousness she was confused and had a severe headache. A CT scan of the brain at [REDACTED] revealed a subarachnoid hemorrhage and right anterior temple contusion. She was then worked up at [REDACTED] because of concern that she might have had an aneurysmal bleed and this was ruled out. [REDACTED] felt that her syncopal episode was most likely vasovagal in origin. She had had a viral infection for a week preceding the symptoms and she had felt dizzy and nauseous before she lost consciousness.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive rehabilitation, unspecified: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Cognitive Behavioral Therapy (CBT) Guidelines for chronic pain..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 7.

Decision rationale: In the medical records provided, [REDACTED] and [REDACTED] both recommended cognitive rehabilitation to help the patient with her memory and with word finding problems. [REDACTED] stated that a speech therapist could help her with this. This type of help is addressed in the Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26,

page 7 as follows: "Multiple treatment modalities, (pharmacologic, interventional, psychosocial/behavioral, cognitive, and physical/occupational therapies) are most effectively used when undertaken within a coordinated, goal oriented, functional restoration approach (see Part 2)." As such, cognitive rehabilitation is medically necessary per MTUS guidelines.

Individual psychotherapy, unspecified: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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. It seems clear that this patient would benefit from psychotherapy, however, the way that the request was phrased, "unspecified" not only fails to specify the type of psychotherapy being requested, but also the frequency and duration. The request is phrased in a way that implies unlimited psychotherapy into perpetuity. This would exceed the limited total of 6-10 visits delineated in the MTUS above. As such, unspecified psychotherapy is not medically necessary.

Lidocaine nasal spray: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26, page 112 states the following about Lidocaine: Indication: Neuropathic pain Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm Â®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label

for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. (Argoff, 2006) (Dworkin, 2007) (Khaliq-Cochrane, 2007) (Knotkova, 2007) (Lexi-Comp, 2008) Non-neuropathic pain: Not recommended. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. (Scudds, 1995) Adequate documentation including a statement of prescription by [REDACTED] show that two different doctors agreed with lidocaine nasal spray. Further, the CA MTUS recommends it as cited above. As such lidocaine nasal spray is medically necessary.