

Case Number:	CM13-0031446		
Date Assigned:	04/25/2014	Date of Injury:	12/14/2009
Decision Date:	11/17/2014	UR Denial Date:	07/16/2013
Priority:	Standard	Application Received:	10/03/2013

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. The expert reviewer is licensed in Psychology, 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 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/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:

According to the records as they were provided for this IMR, this patient is a 61-year-old female patient who reported a work-related injury that occurred on December 14, 2009. According to the patient's report, the injury occurred when she fell down 4 stairs and injured her wrists and knees bilaterally, as well as sprained her right ankle. She subsequently underwent surgery August 2010 which failed, followed by a routine nerve block that caused a severe reaction. She has been diagnosed with CRPS of the left upper extremity and pain related insomnia. Psychologically, she has been diagnosed with the following: pain disorder with both psychological factors and a general medical condition; posttraumatic stress disorder, chronic with panic attacks; phobia medical environments, equipment and procedures; adjustment disorder with mixed anxiety and depressed mood; sleep disorder due to CRPS pain, insomnia type. According to a progress note from her treating psychologist the patient reports: chronic pain, nightmares, flashbacks, hypervigilance, weight gain, loss of strength, sensitivity to touch, isolation, dysfunctional upper extremities, depressed mood, anxiety, failed surgery, sensitivity to vibration, inability to drive her car due to industrial injury, and has trouble writing and holding books and holding onto things. Her pain affects her cognition, such as concentration and speed of thought. Treatment has been recommended for the patient's PTSD and phobias instruction in relaxation response, creation of a homework planner the patient for relaxation practice, and use of EMDR are more systematic desensitization to "initiate metabolism of traumatic medical experiences." She has been participating in weekly psychotherapy sessions however the duration of the treatment was not provided nor was the quantity of sessions she has already received stated. She has also undergone psychiatric care. A treatment note from primary physician from April 2014 states that the patient was only authorized for four sessions rather than the requested 12 and she has completed the four sessions. It is unclear, but possibly her psychological

consultation began on September 7, 2013. In a later progress note from July 2014 also from her primary treating physician it was noted that a request was being made for six additional sessions of psychotherapy and that she underwent some EMDR training recently and "stated that it made her dizzy and that the psychologist is now attempting another strategy." Medically, there is been some discussion of an additional carpal tunnel surgery however she is reluctant given the possibility of her developing further CRPS symptoms. It appears that six sessions were authorized in July 2014. In a comprehensive psychological reevaluation from July 2014 it was mentioned that there the patient was showing signs of the possible stroke. An update to her psychological diagnoses was the addition of a diagnosis of Major Depressive Disorder, Recurrent, Severe and Social Anxiety Disorder (Social Phobia).

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Sessions of Cognitive Behavioral Therapy, Biofeedback Training and Eye Movement Desensitization and Reprocessing: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines behavioral interventions, cognitive behavioral therapy, biofeedback Page(s): 23-25. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress Chapter, topic EMDR, June 2014 update.

Decision rationale: According to the MTUS treatment guidelines, psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. An initial treatment trial is recommend consisting of 3-4 sessions to determine if the patient responds with evidence of measureable/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: a 4 to 6 sessions initial trial followed by up to 13-20 visits over a 7-20 weeks (individual sessions) if progress is being made. In some cases of Extreme Major Depression or PTSD up to 50 sessions, if progress is being made. According to the MTUS treatment guidelines for biofeedback: an initial trial of 3 to 4 psychotherapy visits over two weeks is recommended and with evidence of objective functional improvement a total of up to 6 to 10 visits over a 5 to 6 week period of individual sessions may be offered. Afterwards the patient may "continue biofeedback exercises at home" independently. EMDR is not addressed in the MTUS but is discussed in the ODG which states that the sessions required may be as few as two for uncomplicated PTSD. More sessions are required for multiple or complicated trauma. With respect to this patient, detailed psychological progress notes were provided that discussed the patient's psychological symptomology in sufficient detail to demonstrate that she is continuing to report ongoing anxiety, depression and symptoms of PTSD. However, her history of psychological treatment was insufficiently discussed in a manner that would allow additional sessions to be provided. Her entire psychological treatment history since the time of her injury was not clearly delineated; there were scattered mentions of authorization for six sessions and another for 4 sessions, but the total quantity of sessions could not be

estimated and was not provided. This patient was first injured in 2009 and there is no information regarding any psychological treatment received between 2009 and September 2013 when the current course of treatment appears to have started. It is not even entirely clear exactly when the current treatment began, but September 2013 appears to be the most likely date. There was no information provided with respect to a running total of the quantity of sessions that have been offered. The issuance of continued psychotherapy treatment is contingent upon several factors and not solely patient symptomology. The additional factors include that total session quantity should fall within specific guidelines as stated in the MTUS/ODG (see above). Without knowing how many sessions she has had to date it was not possible to determine whether or not additional sessions would fall within the proper guidelines. One of the treatment modalities being requested, EMDR, apparently was tried and the results caused her to feel "dizzy" with a notation that the treatment modality had been discarded for this patient. However this treatment modality is still being included as a part of this treatment request. Because the quantity of sessions provided appears to have exceeded the recommended guidelines, and there is significant missing information regarding her past psychological treatment, and that one of the requested treatment modalities has already been determined to not be working for her, and that continued treatment does not appear to be meeting the criteria of objective functional improvements which is measured in part by decreased dependency on future medical care as a result of the treatment, the request for additional sessions has not been demonstrated as medically necessary based. The UR decision is therefore upheld. Therefore this request is not medically necessary.