MAXIMUS Federal Services

Case Number:	CM13-0033573		
Date Assigned:	12/06/2013	Date of Injury:	12/08/2007
Decision Date:	03/05/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/10/2013

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 57 year old female injured 12-8-2007. The patient has suffered from a range of orthopedic and psychiatric problems since she was injured. The patient has been diagnosed with depressive disorder N.O.S. with anxiety. In addition the patient has received the diagnosis Psychological Factors Affecting Medical Condition on axis one. The patient's depression is documented as being secondary to her injury and disability. The patient had a trial of psychotherapy at the [redacted] and it was documented on 5-21-13 by [redacted] there that the patient was improving in function as a result of the psychotherapy at [redacted]. She has been treated with Ambien, Atarax and Ibuprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive Behavioral Therapy (CBT) Sessions (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. In this case there is no evidence of a diagnosis of Post Traumatic Stress Disorder. This request for therapy, the way that it is worded, has no apparent limits or endpoint to treatment. As such, the request appears to denote unlimited CBT. Unlimited psychotherapy sessions exceeds that guideline and as such are not medically necessary per MTUS.

CBT 3-4 Sessions and one medication management session in the next 45 days: 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): 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. In this case there is no evidence of a diagnosis of Post Traumatic Stress Disorder. In this case [redacted] has documented increases in function as a result of psychotherapy. Four psychotherapy sessions falls within the guideline and as such is medically necessary per MTUS.

Twenty (20) weekly group psychotherapy sessions: 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. In this case there is no evidence of a diagnosis of Post Traumatic Stress Disorder. Although this patient has done well with psychotherapy and it is documented that she increased her functioning level as a result of past psychotherapy, twenty psychotherapy sessions exceeds that guideline and as such are not medically necessary per MTUS.

CBT not > once every other week for (13 sessions): 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. In this case there is no evidence of a diagnosis of Post Traumatic Stress Disorder. Although this patient has done well with psychotherapy and it is documented that she increased her functioning level as a result of past psychotherapy, thirteen psychotherapy sessions exceeds that guideline and as such are not medically necessary per MTUS.

Biofeedback 4 Sessions: 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): 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 to6-10 visits over 5-6 week

Medication Management Sessions if indicated every 2-3 months over the next 6 months as needed: 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): 27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress, office visits; Practice Guideline for the Treament of Patients with Major Depressive Disorder, Third Edition; and http://psychiatryonline.org/content.aspx?bookID=28&sectionID=1667485#654226

Decision rationale: 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 patient has been treated with Ambien and Atarax. The guidelines are clear that ambien should be short term, and this requires the oversight of physician trained and experienced in monitoring medication such as ambien. Not only does this patient need some medication management visits with a psychiatrist in the short term but will need ongoing psychiatric medication management visits with a psychiatrist over the medium and long term 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. Medication management visits every two months for six months are medically necessary.