

Case Number:	CM13-0035301		
Date Assigned:	12/13/2013	Date of Injury:	10/05/2005
Decision Date:	02/10/2014	UR Denial Date:	09/26/2013
Priority:	Standard	Application Received:	10/17/2013

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 & Neurology, has a subspecialty in Geriatric Psychiatry and Addiction Medicine 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:

The claimant is a 47-year-old male employed as an industrial electrician, who was diagnosed with adjustment disorder with mixed anxiety related to his industrial injury. His date of injury is 10/05/05, which occurred when he fell stepping off of a curb, breaking his right lower leg. However, in a comprehensive pain management consultation report on 8/1/13 by [REDACTED], QME, the patient reports that the injury occurred when he stepped on the edge of a platform approximately three feet high with a piece of concrete missing, and he slipped and fell. He landed with his right foot and leg twisted, felt a crack, fell back to avoid hitting his head, and put his right hand on the ground. He underwent intramedullary rodding of the right tibia on 10/6/05. In 10/05 he underwent right knee surgery, then in 2007 a second right knee surgery. On 3/20/13, he underwent a right sacroiliac joint injection, from which he received more than 80% relief for approximately 5 months. In 2007, the claimant had a sleep consultation by [REDACTED] and was diagnosed with mild obstructive sleep apnea syndrome, sleep onset and maintenance insomnia, suboptimal delta and REM sleep, and excessive daytime sleepiness as verified by the MSLT. A Sleep Medicine evaluation by [REDACTED] of 9/5/13 report that patient used CPAP until he lost a power cable 2-3 weeks ago, however despite using the CPAP he continues to feel sleepy during the day and takes Ambien nightly. The patient reports that due to his industrially related pain and stress, he has developed physical symptoms, one of which is a sleep disorder. Epworth Sleep Scale score is 20, suggesting the presence of a sleep disorder. He was given the diagnoses of obstructive sleep apnea syndrome, mild but may be worse; sleep onset and maintenance insomnia, and excessive daytime sleepiness due to #1 and #2. Recommendations included another titration study, after which a follow up in approximately 6 months or sooner if needed. There

IMR ISSUES, DECISIONS AND RATIONALES

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

psychotherapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Psychotherapy Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Behavioral Interventions Page(s): 23 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cognitive Behavioral Therapy (CBT) Guidelines for Chronic Pain

Decision rationale: CAMTUS 2009 refers to the use of psychotherapy for the treatment of pain. ODG references cognitive behavioral therapy for the treatment of chronic pain and in the treatment of major depressive disorder. This worker was originally treated for an adjustment disorder, which was later (late in his course) changed diagnostically to a major depression. That being said, the worker's psychotherapy treatment began somewhere in 2010 and continued on through 2013. There is no evidence from records provided that he has markedly benefited from same. Per ODG, psychotherapy as a modality (cognitive behavioral therapy) is designed to show increasing progress over time. There is no evidence that this patient was receiving any form of cognitive behavioral therapy, or that he was making progress in the therapy, which was delivered. As such, authorization of further psychotherapy services would be indicated. The request is therefore denied. CAMTUS 2009: 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). Psychotherapy for MDD (major depressive disorder) Recommended. Cognitive behavioral psychotherapy is a standard treatment for mild presentations of MDD; a potential treatment option for moderate presentations of MDD, either in conjunction with antidepressant medication, or as a stand-alone treatment (if the patient has a preference for avoiding antidepressant medication); and a potential treatment option for severe presentations of MDD (with or without psychosis), in conjunction with medications or electroconvulsive therapy. Not recommended as a stand-alone treatment plan for severe presentations of MDD. (American Psychiatric Association, 2006) See also cognitive therapy for additional information and references, including specific ODG Psychotherapy Guidelines (number and timing of visits). Patient selection. Standards call for psychotherapy to be given special consideration if the patient is experiencing any of the following: (1) Significant stressors; (2) Internal conflict; (3) Interpersonal difficulties/social issues; (4) A personality disorder; & (5) A history of only partial response to treatment plans, which did not

