Case Number:	CM13-0035306		
Date Assigned:	12/13/2013	**Date of Injury:**	11/10/2005
Decision Date:	02/10/2014	**UR Denial Date:**	09/20/2013
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 53-year-old female whose date of injury was 11/10/05. She was employed as a special education specialist in the [redacted]. Diagnoses include bilateral knee OA and PFC. On 3/20/13, the claimant underwent an evaluation of fitness for medical procedures (spinal cord stimulation) conducted by [redacted], QME, licensed psychologist. She stated it was raining and while she was walking towards the classroom, she slipped on a muddy sidewalk and fell backwards. She stated that she twisted her knees and landed on her back. She recalled that it "knocked the wind out of me". She was referred to the company clinic and subsequently was evaluated by numerous physicians, then receiving treatments including injections and epidurals. In 06/08, she underwent anterior lumbar fusion surgery and lumbar decompression in 09/08, after which she developed residual nerve damage in the right leg. She had left knee arthroscopy in 04/11. Also in 04/11 she received Synvisc injections to her left knee which still buckles and is painful, also noting that she developed pain in the right knee as a compensatory consequence. She was unable to return to work and no work restrictions were available, experiencing chronic pain, fibromyalgia, tingling and sharp nerve pain radiating from the back to the right leg with a rating of 7/10 without medication. Medications include Amitiza 14mg twice a day as needed, Senexon once-twice a day, Lyrica 25mg 3 times a day, Ambien, Restoril, Naproxen sodium 550mg once-twice a day, Metanx 3 times a day, and Cymbalta 60mg once a day. Due to the ongoing pain, the patient developed depression, anxiety, sleeplessness and hair loss. Her major pain complaints include pain in the back and right knee. Emotional and cognitive symptoms include tension, sleeplessness, anxiety, depression, fatigue, helplessness, nervousness, frustration, confused thoughts, poor concentration, anger, exhaustion, irritability, self-doubt

IMR ISSUES, DECISIONS AND RATIONALES

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

psychological evaluation: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-102.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations Page(s): 100-101.

Decision rationale: According to CAMTUS 2009, psychological evaluations are accepted as diagnostic procedures in chronic pain populations to determine if further psychosocial interventions are indicated and necessary. They can be used to determine what, if any further effective rehabilitation measure is necessary. In this case, although the patient was originally evaluated by a psychologist, this was only for the purpose of determining fitness for medical procedures (in this place implantation of a spinal cord stimulator). Since the date of the original injury (11/2005), she has developed a plethora of emotional problems, apparently as a consequence of the industrial injury. This is an indication for a psychological evaluation to help determine how much of the current psychological picture is relative to the original injury vs. pre-existent factors and what role, if any; ongoing cognitive behavioral therapy would play in the treatment of her current pain condition. CAMTUS 2009: Psychological evaluations Recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. (Main-BMJ, 2002) (Colorado, 2002) (Gatchel, 1995) (Gatchel, 1999) (Gatchel, 2004) (Gatchel, 2005) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. (Gatchel, 1999) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. (Goldberg, 1999) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. (Linton, 2002) Other studies and reviews support these theories. (Perez, 2001) (Pulliam, 2001) (Severeijns, 2001) (Sommer, 1998) In a large randomized controlled trial (RCT) the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. (Lin-JAMA, 2003) See "Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients" from the Colorado Division of Worker

psychological treatment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 101-102.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment Page(s): 101-102.

Decision rationale: CAMTUS allows for appropriately identified patients to receive psychological intervention for chronic pain. This is usually in the form of cognitive behavioral therapy, which has a positive short-term effect on pain interference. In this case, however there has not been adequate evaluation of the patient to determine if this form of treatment would be necessary. A psychological evaluation is necessary first to determine if the patient will in fact benefit from said therapy before it can be authorized. Therefore, the treatment is denied at this time. CAMTUS 2009: Psychological treatment recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point, a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. See also ODG Cognitive Behavioral Therapy (CBT) Guidelines. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005).