

Case Number:	CM13-0036412		
Date Assigned:	10/03/2014	Date of Injury:	10/28/2002
Decision Date:	10/30/2014	UR Denial Date:	10/02/2013
Priority:	Standard	Application Received:	10/21/2013

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 clinical 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 medical records, this patient is a 51-year-old female who reported an industrial/occupational injury that occurred during her normal and usual work duties for [REDACTED] on October 28, 2002. There appears to be a second date of injury of November 6, 2006 but no information regarding that injury. The injury in 2002 reportedly occurred while she was assisting a customer to remove a bike from a box and felt a pop in her elbow. She has severe neck pain that radiates into her left arm and left hand. She is currently diagnosed with Cervical Post Laminectomy Syndrome; bilateral carpal tunnel release; upper extremity cervical radiculopathy; cervical stenosis status post fusion C-3 to C-7. This IMR will focus on symptoms related to her psyche as they relate to the request for treatment being considered. Primary treating physician progress note from October 2012 conveys the following psychological diagnoses: Anxiety State Not Otherwise Classified; and Depression, Chronic. The same note mentions that she completed a four-week functional restoration program and was able to discontinue fentanyl and decrease opiate use and that her depression and anxiety are still present but has improved significantly. A psychological report from her primary treating Psychologist dated March 2013 mentions that her anxiety began suddenly when she took her dog out to get the mail and experienced a panic attack with rapid heartbeat and thoughts that she was dying. The panic attacks became more frequent and started to occur any time she left her home and eventually started to happen even in her home. She reports having tried medication and biofeedback but they did not help her anxiety. She reports that her depression started after her injury that she was trying to help a pregnant lady loaded bicycle and now her injury has completely changed her entire life. She says the anxiety is usually manageable and does not last too long but the depression is horrible. She reports sadness, hopelessness, having problems with her family. She reports being in a "dark place" and has considered suicide. She has been diagnosed with the

following: Mood Disorder Due To Chronic Pain; Panic Disorder with Agoraphobia. Treatment plan was weekly psychotherapy sessions until anxiety and depression decrease. There were no treatment progress notes from her psychologist regarding how many sessions, and the outcome of the sessions, following this report. This report consists of the only documentation provided by the primary treating psychologist. Primary treating physician progress note from July 2013 states patient's depression and anxiety are better with medication. Poor sleep is reported. She reports constant neck, shoulder, and upper extremity pain and psychologically reports depression and anxiety. She reports severity of psychological symptoms to be at 9/10, where 10 is the worst. She is taking both Effexor and Cymbalta. The note additionally states that the patient has been receiving psychological treatment and should be allowed to continue to do so. Spinal cord stimulator being considered. Primary treating physician progress note from September 2013 states that the patient remains off work and reports persistent and constant neck and shoulder pain, decreased range of motion, carpal tunnel syndrome, cervical spondylosis, and neuropathic pain. A request was made for cognitive behavioral therapy four sessions, the request was noncertified. Utilization review rationale for non-certification states that medical records do not clearly establish objective and measured functional gains, improvements with activities of daily living, or discussions regarding returned to work as a result of previous psychotherapy and that proposed number of visits in addition to the number of visits already completed would exceed guideline recommendations. This independent medical review will address a request to overturn that decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

CBT sessions x4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment Page(s): 19-23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part Two, Behavioral Interventions, Cognitive Behavioral Therapy Page(s): 23-24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress Chapter, topic: cognitive behavioral therapy, psychotherapy guidelines, June 2014 update.

Decision rationale: The MTUS treatment guidelines for cognitive behavioral therapy specify that after initial trial of 3 to 4 sessions, if objective functional improvements are being made in treatment, that additional sessions up to a maximum of 6-10 can be offered. The official disability guidelines for psychological therapy, cognitive behavioral therapy, state the patients who are making progress in treatment may have up to a maximum of 13-20 sessions. The quantity of prior sessions already provided was not reported making it impossible to determine if the request for 4 additional sessions falls within these guidelines. There were no prior treatment progress notes from her psychologist regarding recent past psychotherapy sessions, there was no documentation of the total quantity of sessions the patient has already completed of psychotherapy since the start of her psychological treatment for this injury during the past 12 years, there was no documentation of any objective functional improvements that have resulted specifically from her psychological treatments provided by her current treating psychologist. Her

primary treating physician does refer to her psychological treatment in his treatment notes, but it do not provide sufficient detail regarding the treatment and the patient's response to it; the documentation provided is insufficient, provided from an indirect source, and does not establish sufficient objective functional improvements and to meet the criteria of medical necessity. Therefore, the request is not medically necessary.