

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM13-0043242 |                              |            |
| <b>Date Assigned:</b> | 04/25/2014   | <b>Date of Injury:</b>       | 06/21/2002 |
| <b>Decision Date:</b> | 07/04/2014   | <b>UR Denial Date:</b>       | 09/17/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/22/2013 |

### 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 Board Certified in Occupational 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 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:

The patient is a 50-year-old male who has submitted a claim for cervicalgia, impingement syndrome of the left shoulder, posttraumatic stress disorder, panic disorder without agoraphobia, major depressive disorder without psychotic features, and generalized anxiety disorder associated with an industrial injury date of June 21, 2002. Medical records from 2013 were reviewed, the latest of which dated October 31, 2013 revealed that the patient still complains of pain in the shoulders, cervical, thoracic, and lumbar spine. The patient has not done well with medications. On physical examination, there was limitation in range of motion of the cervical spine, 25-50% in all planes. There is noted tenderness and muscle guarding. The shoulders have a painful arc but negative for drop arm sign. On psychological examination done last October 22, 2013, the patient was noted to have appropriate affect, positive attitude, improved mood, good behavior, oriented to the three spheres, well-nourished, improved motor activity, good attention and concentration. He has an average speech rate and volume with good articulation, fair to good coherence and good spontaneity. He has a good rate of thoughts and reasoning. There are some distractions in testing the short term memory, but overall appropriate. The patient has good judgment, fair insight, average intelligence, appropriate perceptions and impulsivity. There were no hallucinations or delusions with good thought content and improved thought process. Treatment to date has included right shoulder Mumford procedure (4/18/03), left shoulder Mumford procedure (2/4/04), individual psychotherapy, biofeedback, and medications which include Adderall, Abilify, Cymbalta, Baclofen, Klonopin, Soma, Norco, Skelaxin, Seroquel, Paxil, Valium, and ibuprofen. Utilization review from September 17, 2013 denied the requests for PSYCHOTHERAPY (MONTHLY) QTY: 4.00 and GROUP THERAPY (BI-WEEKLY) QTY:4.00 because there has been long-term psychotherapy and there is a need for detailing of functional improvement and medical necessity for ongoing treatments; and denied the request for

REFERRAL FOR PHYSICAL THERAPY (QTY: 14.00) because there is no detailed current musculoskeletal history and physical examination. Functional impairments, daily activities, and the rationale for the further physical therapy are not stated.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **PSYCHOTHERAPY (MONTHLY) QTY: 4.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines BEHAVIORAL INTERVENTIONS Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 19-23.

**Decision rationale:** According to pages 19-23 of the CA MTUS Chronic Pain Medical Treatment Guidelines, behavioral modifications are recommended for appropriately identified patients during treatment for chronic pain to address psychological and cognitive function and address co-morbid mood disorder. The guidelines recommend an initial trial of 3-4 psychotherapy visits over 2 weeks and with evidence of functional improvement, a total of 6-10 visits over 5-6 weeks. In this case, the patient has had previous individual psychotherapy since December 2012 to address depression and anxiety disorders. In the most recent clinical evaluation, there is no subjective and objective finding that warrants further psychiatric treatment. Additional psychotherapy will exceed guideline recommendation. Therefore, the request for PSYCHOTHERAPY (MONTHLY) QTY: 4.00 is not medically necessary.

#### **GROUP THERAPY (BI-WEEKLY) QTY:4.00: 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 9792.24.2 Page(s): 19-23.

**Decision rationale:** According to pages 19-23 of the CA MTUS Chronic Pain Medical Treatment Guidelines, behavioral modifications are recommended for appropriately identified patients during treatment for chronic pain to address psychological and cognitive function and address co-morbid mood disorder. The guidelines recommend an initial trial of 3-4 psychotherapy visits over 2 weeks and with evidence of functional improvement, a total of 6-10 visits over 5-6 weeks. In addition, Official Disability Guidelines state that group therapy should provide a supportive environment in which a patient with posttraumatic stress disorder (PTSD) may participate in therapy with other PTSD patients. In this case, the patient has had previous individual psychotherapy since December 2012 to address depression and anxiety disorders. In the most recent clinical evaluation, there is no subjective and objective finding that warrants further psychiatric treatment with group therapy. Additional psychotherapy will exceed guideline

recommendation. Therefore, the request for GROUP THERAPY (BI-WEEKLY) QTY:4.00 is not medically necessary.

**REFERRAL FOR PHYSICAL THERAPY (QTY: 14.00): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98,99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 98-99.

**Decision rationale:** According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In addition, guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. In this case, referral for physical therapy was requested; however, the rationale is unknown due to lack of documentation. In the most recent clinical evaluation, there are insufficient subjective and objective findings including functional impairments and daily activities that warrant further treatment with physical therapy. The goals of therapy are not documented. Therefore, the request for REFERRAL FOR PHYSICAL THERAPY (QTY: 14.00) is not medically necessary.