

<b>Case Number:</b>	CM13-0047851		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	05/12/2007
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	10/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

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

Records reviewed include 1655 pages of medical and administrative records. The injured worker is a 34 year old female whose date of injury is 05/12/2007, at which time she twisted her back with ensuing low back pain and sciatic symptoms. On 9/09/13 a panel qualified medical re-evaluation was performed by [REDACTED], orthopedic surgeon. The patient was diagnosed with annular disc injuries. She received injection therapy and had an IDET procedure, with no relief from either. She has been in a chronic pain management program for constant mid-low back pain with medications gabapentin, Ambien, Zanaflex, Morphine, Dilaudid, Prozac, Senna, and Prilosec), physical therapy, and the insertion of a spinal cord stimulator, which was removed as it worsened her symptoms. She had sleep disturbance which contributed to her depression due to fatigue, and felt depressed due inability to participate in previous activities and social isolation. She reached maximum medical improvement at the time of this report. On 10/25/13 a psychiatric AME was performed by [REDACTED]. The patient began individual psychotherapy with her current psychologist, [REDACTED], with whom she has received weekly to biweekly individual psychotherapy. [REDACTED] assigned her the primary diagnosis of pain disorder with psychological factors and a general medical condition, she later added major depressive disorder. She was started on Cymbalta in 2009 or 2010 for the dual purpose of antidepressant and chronic pain, up to 120mg per day, which was later changed to Prozac. She was given Ambien in 2010. She denied suicidal/homicidal or psychotic symptoms in any modality. She endorsed monthly crying spells, and uncharacteristic irritability and impatience, impaired concentration, as well as social phobia, generalized anxiety, and panic disorder symptoms. Since 2009 she said that she has felt guilt, hopelessness, helplessness, and decreased energy. Sleep was reportedly 2-3 hours during the day and 7 hours per night with

awakening due to pain. ██████ felt that she also had depressive disorder NOS with anxiety features. Medications included Metformin, Lisinopril, gabapentin 600mg TID, Morphine sulfate 120 mg per day, Dilaudid 4 mg every 4 hours as needed for pain (she attested to taking 5-6 per day), Zanaflex, Prozac 40mg, Ambien 10mg, Pravastatin, and Prilosec. ██████ treatment summaries of 12/19/12 and 02/11/13 both show the patient as suffering from increased depression and anxiety due to chronic pain, failed surgeries, and inability to work. Her coping skills had improved and she was less tearful and angry but she was more socially withdrawn. At that point she had received 85 psychotherapy treatments. ██████ 12/19/12 evaluation notes worsening in the patient's Beck Depression and Anxiety inventories between 12/11 and 12/12, and no improvement in the symptom checklist or Beck Hopelessness Scale. On 05/28/13 the patient complained of increased lower extremity numbness and tingling, migraine headaches, sleep disturbance, feeling tired, and right shoulder pain, and felt frustrated due to chronic pain.

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

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

#### **8 PSYCHOTHERAPY SESSIONS FOR 1 HOUR BETWEEN 9/13/2013 AND 11/7/2013:**

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 Behavioral Interventions Page(s): 23 of 127.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** Per CA-MTUS behavioral interventions are 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. 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). The patient had been receiving cognitive behavioral therapy since at least 2011, and as of around 02/13 she had received 85 sessions, which well exceeds ODG guidelines of 6-10 visits over 5-6 weeks with evidence of functional improvement. As of 10/25/13 she continued to endorse feelings of irritability, impatience, impaired concentration, social phobia, generalized anxiety, and panic disorder symptoms. Per ██████ reports, there was worsening of the patient's Beck Anxiety and Depression scores between 12/11 and 12/12, and no change in the symptom checklist or hopelessness scale. Her coping skills had improved, but she was more socially withdrawn, and ██████ reported the patient as increasingly depressed and anxious due to chronic pain. Her pain was not alleviated by her medication regimen and the patient did not

show functional improvement with psychotherapy since its inception. As such, this request is not medically necessary.