

<b>Case Number:</b>	CM13-0051806		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	08/31/2011
<b>Decision Date:</b>	07/23/2014	<b>UR Denial Date:</b>	11/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2013

### 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 and 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 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 records reviewed included 98 pages of administrative and medical records. The injured worker is a 49-year-old male, whose diagnoses include major depression single episode mild, anxiety disorder not otherwise specified, male hypoactive sexual desire disorder, due to chronic pain, and insomnia, due to mental disorder. His date of injury is 08/31/2011. A neurological & pain management narrative progress report & request for authorization, from [REDACTED], dated 05/28/13 indicates that the patient had painful movement in his shoulders. He rated his depression as 8/10, continued to be anxious, had problems sleeping, felt current pain/discomfort were severely impacting his general activity and enjoyment of life, ability to concentrate, and interact with others. He received trigger point injections and prescriptions for Tizanidine, Tramadol, and hydrocodone. A neurological & pain management narrative progress report & request for authorization, from [REDACTED], dated 09/17/13 indicated that the patient complained of frequent pain and numbness in his right arm and elbow (ulnar neuropathy), painful movements of his shoulders. He rated his depression as 6/10, continued to be anxious, had more problems sleeping, felt current pain/discomfort moderately impacted his general activity and ability to work/severely impacted enjoyment of life, ability to concentrate, and interact with others. He received trigger point injections and prescriptions for Tramadol, hydrocodone, and Mirtazapine. There were similar records from [REDACTED] from April 2013 and prior, showing the patient as rating his depression 8/10 and listing, as above (almost verbatim), feeling that his current pain and discomfort was moderately to severely impacting his enjoyment of life.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MEDICAL HYPNOTHERAPY ONE (1) TIME PER WEEK FOR SIX (6) WEEKS:**

Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 387-413. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress, Hypnosis.

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that stress management techniques may be offered as a way to help reduce symptoms of stress and give the patient control over stressful situations and offer a measurable and concrete result. The choice of a technique may be influenced by the patient's presenting symptoms. Some techniques are offered alone or in conjunction with other modalities, such as hypnosis. The Official Disability Guidelines indicate that this is recommended as an option. Hypnosis is a therapeutic intervention that may be an effective adjunctive procedure in the treatment of post-traumatic stress disorder (PTSD). Various meta-analysis of studies on the treatment of anxiety, pain, and other conditions imply that hypnosis can substantially enhance the effectiveness of psychodynamic and cognitive behavioral therapies (CBTs); however, most of the literature on the use of hypnosis for PTSD is based on service and case studies. Hypnotic techniques have been reported to be effective for symptoms often associated with PTSD such as pain, anxiety and repetitive nightmares. Hypnosis should only be used by credentialed health care professionals, who are properly trained in the clinical use of hypnosis and are working within the areas of their professional expertise. The number of visits should be contained within the total number of psychotherapy visits. There is no evidence from records provided for review of what benefit the hypnotherapy would be to the injured worker and with what other modality it will be provided. This must be specified prior to approval of hypnotherapy, along with the number of treatments to date (if any), measurable goals, and functional improvement. The request is not medically necessary.

**GROUP MEDICAL PSYCHOTHERAPY ONE (1) TIME PER WEEK FOR SIX (6) WEEKS:** 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 Psychological treatment Page(s): 101-102.

**Decision rationale:** The Chronic Pain Guidelines indicate that psychological treatment is 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). The guidelines also indicate that cognitive behavioral therapy and self-regulatory treatments 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. During the office visits, there were ratings for the patient's depression as well as a list of other symptoms that the injured worker was experiencing. There are no detailed psychological evaluations or assessments provided which describe the condition for which group psychotherapy is being requested, objective and measurable goals, or functional improvement. In his requests for authorization, the treating physician makes no mention of group medical psychotherapy. The number of visits that has been received to date, if any, has not been specified. The request is not medically necessary.

**OFFICE VISITS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** The MTUS/ACOEM guidelines indicate that follow-up visits may be determined by the severity of symptoms, whether the patient was referred for further testing and/or psychotherapy, and whether the patient is missing work. The Official Disability Guidelines indicate that office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of the necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. The patient is being treated for pain management. There is no quantity or frequency of office visits in this request. The request is not medically necessary.