

<b>Case Number:</b>	CM13-0061662		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	06/06/2011
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2013

### 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 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:

The patient has submitted a claim for chronic pain syndrome, cervical facet spondylosis, depression, and insomnia associated with an industrial injury date of 06/06/2011. Treatment to date has included ACDF C4-5 and revision fusion C5-6 on unspecified dates, cervical transforaminal epidural steroid injections x 2 sessions, physical therapy x 4 visits, TENS unit, and medications including Norco, Protonix, Lyrica, Ambien, Senna and Cymbalta. Medical records from 2012 to 2013 were reviewed showing that patient has been complaining of chronic neck pain radiating to the right upper extremity. It was described as constant, deep ache with intermittent spasm graded 4/10. This was aggravated by activity and relieved by rest and intake of medications. The patient also had a history of anxiety, depression, insomnia, loss of function and lifestyle change related to her chronic pain. Physical examination showed decreased cervical lordosis. There was tenderness at bilateral upper trapezius and paracervical areas, right greater than left. Range of motion of cervical spine was decreased in all planes with presence of pain during right lateral flexion and rotation towards the right. Range of motion of the right shoulder showed mild limitation with pain reproduction in the left shoulder on adduction and external rotation. Impingement testing was positive on the right. There was increased sensitivity to light touch at C6 and C7 dermatomes at right. X-ray of the cervical spine, dated 02/20/2013, showed solid fusion status post anterior cervical discectomy and fusion of C4-C5. CT scan of the cervical spine, dated 05/29/2013, revealed anterior cervical discectomy and fusion change at C4-C6 with hardware placement at C4-C5. Mild central canal stenosis and mild bilateral neural foraminal stenosis at C6-C7. Endplate osteophyte formation at upper C6 endplate with mild central canal stenosis at C5-C6. Electromyography and nerve conduction tests performed on 02/14/2013 showed normal findings. A progress report written on 11/11/2013 showed that patient was seen

by a psychologist who evaluated her chronic pain. Treatment plans included six sessions of biofeedback and six sessions of cognitive behavioral therapy.

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

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

**COGNITIVE THERAPY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: Chronic Pain Medical Treatment Guidelines, , 19-23

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines §§9792.20 - 9792.26 Page(s): 23, 101.

**Decision rationale:** As stated in page 101 of CA MTUS Chronic Pain Medical Treatment Guidelines, psychological intervention for chronic pain includes addressing co-morbid mood disorders (such as depression, anxiety, and posttraumatic stress disorder). Page 23 states that initial therapy for these at risk patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Initial psychotherapy of 3-4 visits over 2 weeks is the recommendation. In this case, medical records submitted for review showed that the patient has been experiencing anxiety, depression and insomnia related to her chronic pain. She has also completed four visits to physical therapy to date, however with minimal improvement. The medical necessity for cognitive therapy appears to be consistent with the MTUS guidelines noted above, however, the present request did not specify the number of sessions and its frequency per week. Therefore, the request for cognitive therapy is not medically necessary.