

Case Number:	CM13-0067103		
Date Assigned:	01/03/2014	Date of Injury:	09/21/2006
Decision Date:	09/29/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/17/2013

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 Psychologist and is licensed to practice in Texas. 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 injured worker is a 55-year-old female with a reported date of injury on 09/21/2006. The mechanism of injury was noted to be from a slip and fall. Her diagnoses were noted to include depressive and anxiety disorder. Her previous treatments were noted to include cognitive behavioral psychotherapy and psychotropic medications. The psychologist's progress note dated 07/03/2014 revealed complaints of depression, anxiousness/stress, nervousness, and forgetfulness. The provider reported markedly depressed and moderately anxious mood, blunted affect, noticeable psychomotor slowing persistently dysthymic, dysphoric, anhedonic, and anergic. The psychologist's progress note dated 08/30/2013 revealed complaints of depression, anxiousness/stress, nervousness and forgetfulness. The provider indicated the injured worker was markedly depressed and moderately anxious, had a blunted affect, noticeable psychomotor slowing, persistent dysthymic, dysphoric, anhedonic, and anergic. The psychologist's progress note dated 10/10/2013 revealed complaints of depression, decreased sleep due to pain. The objective findings noted no suicidal ideations. The psychology progress note dated 11/01/2013 revealed complaints of depression, anxious/stress, nervousness and forgetfulness. The provider indicated the injured worker was markedly depressed and moderately anxious, with a blunted affect, noticeable psychomotor slowing, persistently dysthymic, dysphoric, anhedonic, and anergic. The Request for Authorization form dated 11/01/2013 was for 12 cognitive behavioral psychotherapy sessions, however the providers rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

12) Sessions PF Cognitive Behavioral Psychotherapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Non-MTUS, Official Disability Guidelines, Cognitive Behavioral Therapy (CBT) guidelines for chronic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PSYCHOLOGICAL TREATMENT Page(s): 101-102.

Decision rationale: The request for 12 sessions PF cognitive behavioral psychotherapy is not medically necessary. The injured worker has received previous cognitive behavioral psychotherapy treatments. The California Chronic Pain Medical Treatment Guidelines recommend psychological treatment for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conventionalizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing comorbid mood disorders. Cognitive behavioral therapy and self regulatory treatments have been found to be particularly effective. Psychological treatment 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 approach to pain management that involves psychological intervention has been suggested to 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 and how to screen for patients that may need early psychological intervention, 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. If the pain is sustained in spite of continued therapy including psychological care then intensive care may be required from mental health professionals allowing for a multidisciplinary treatment approach. The guidelines recommend up to 13 to 20 visits over 7 to 20 weeks (individual sessions), if progress is being made. There is a lack of documentation regarding subjective and objective findings to warrant additional cognitive behavioral psychotherapy treatments. Therefore, due to the lack of documentation with demonstrable evidence of subjective, objective, or functional benefit as a result of treatment the ongoing cognitive behavioral psychotherapy is not appropriate at this time. Therefore, the request is not medically necessary.