

<b>Case Number:</b>	CM14-0009995		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	08/19/2009
<b>Decision Date:</b>	06/25/2014	<b>UR Denial Date:</b>	12/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/24/2014

### 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, Geriatric Psychiatry, and Addiction Psychiatry and is licensed to practice in California and 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:

Records reviewed include 280 pages of medical and administrative records. The injured worker is a 49 year old male whose date of injury is 08/19/2009, when he fell through a scaffold to the next lower level. His psychiatric diagnosis at the time of this request is depressive disorder not elsewhere classified. He suffered 3 impacts: to his groin, back, and upper back. He experienced right radicular pain, trochanteric bursitis, low back pain, and left lower extremity numbness and tingling. He received (at different times) corticosteroid + local injections, Naproxen, Ultram, Vicodin, gabapentin, omeprazole for GI upset from the NSAID. In 2010 he saw a psychologist (██████████), who found psychological symptoms of sleep disruption, anhedonia, loss of sexual interest, and suicidal thoughts. In 2011 he reported suicidal thoughts without plan, lack of sexual interest, and delayed ejaculation. In a May 2013 report by ██████████ the patient reported having had weekly psychology visits, a total of 9 at that time. He described himself as nervous, tense, depressed in mood, avoidant, and isolating himself in his room for long periods of time. Affect was detached, thought process was goal directed and somatically preoccupied, memory was adequate. Beck Depression and Beck Anxiety were reportedly in the severe range, however scores were not given. In June 2013 he reported feeling overall better with psychological/psychiatric treatment. He had recurrent nightmares 2-3 times per week of falling to his death but they were less frequent. The patient had been on Cymbalta for 5 months and noted that he still felt depressed but had no plans of self harm. He was receiving monthly psychological treatment. He continued to report sexual dysfunction and forgetfulness. A consultation of 12/16/13 by ██████████ determined the patient's GAF to be 55, and he was in 2011. Psychiatric progress report of 12/19/13 by ██████████ shows the patient reporting as feeling improvement in anxiety and feeling calmer, attributed to increased Cymbalta. Life stressors and pain were unchanged. Affect was restricted, diagnosis given was

major depressive disorder, first episode, improving, and weekly CBT was recommended. This is somewhat confusing given [REDACTED] report above. [REDACTED] opined that the patient's depression had improved but not to the desired level, however that level was not specified or quantified by a rating scale or level of objective functional improvement. [REDACTED] psychiatric progress report of 01/24/14 the patient reported feeling better, with improvement in anxiety attributed to increased Cymbalta manifested by feeling calmer and "overall better". His current complaint was inability to sleep more than 4-5 hours per night. Life stressors were unchanged. He had undergone a sleep study (results not yet available). Depression was still described as "improved although not to the desired level." Affect was restricted, no memory impairment, thought process organized, logical, and goal directed. He denied suicidal/homicidal/psychotic ideation, and there were no delusions present. [REDACTED] gave him the diagnosis of major depressive disorder, first episode, improving. He was continued on Cymbalta 90mg and was given Trazodone 50mg QHS as needed.

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

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

#### **COGNITIVE BEHAVIORAL THERAPY 1 X 6-12: 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, COGNITIVE BEHAVIORAL THERAPY,

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES , BEHAVIORAL INTERVENTIONS, 23

**Decision rationale:** CA MTUS/ODG recommends 6-10 visits over 5-6 weeks of individual sessions with evidence of objective functional improvement. In May 2013 the patient reportedly had at least 9 psychotherapy visits. I could not ascertain when he began psychotherapy. Beck Depression and Beck Anxiety scales were apparently given but scores were not provided. In June's reports he was noted to feel improvement in symptoms with psychotherapy and psychiatric services, as well as with medications. Improvement continued to be reported up to and including [REDACTED] report of 01/14/2014. There no metric scales to quantify objective functional improvement, there are only vague statements as noted above. The total number of psychotherapy sessions used to date has not been specified but as of May he had used 9 and in June had continued to be seen in psychotherapy. Based on the patient falling within the aforementioned ODG guidelines he does not meet medical necessity for ongoing psychotherapy care. Therefore I recommend that this request is for Cognitive Behavioral Therapy 1x 6-12 is not medically necessary.