

<b>Case Number:</b>	CM14-0103199		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	10/02/2008
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	06/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 57 year old female who reported an injury on 10/02/2008; the mechanism of injury was not provided. Diagnoses included lumbar sprain/strain and radiculitis, depression disorder, and anxiety. Past treatments included a behavioral pain management therapy, individual and group psychotherapy, chiropractic care, home exercise program, ultrasound therapy, heat therapy, and a cane. Diagnostics and surgical history were not provided. The clinical note dated 06/10/2014 indicated the injured worker complained of pain rated 8/10 to her back. She reported being unable to do most activities of daily living and feelings of sadness, social avoidance, a sense of hopelessness, and crying episodes but denied suicidal ideation. She also reported feelings of insecurity, fears of dying, health worries, social apprehension, and lack of concentration. Objective findings indicated a Beck Anxiety Inventory score of 38, Beck Depression Inventory score of 23, and Pain Catastrophizing Scale of 43. Clinical risk factors found during the interview included data to suggest self-destructive behavior or aggressive propensity. Current medications included Topiramate 50 mg, Venlafaxine ER 75 mg, Tramadol 50 mg, Lidopro, and Norco 5/325 mg. The treatment plan included six cognitive behavior therapy sessions. The rationale for treatment included that the injured worker had pain induced emotional and behavioral symptoms, was experiencing depression and significant neuro vegetative symptoms, had poor coping skills and difficulty in pain management, and acknowledged the presence of suicidal detection in response to injured condition, pain and disability status. The request for authorization form was submitted on 06/11/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **6 Cognitive Behavior Therapy sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG Guidelines Cognitive Behavioral Therapy (CBT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23.

**Decision rationale:** The injured worker complained of pain 8/10 in her back, reported being unable to do most activities of daily living, and feelings of sadness, social avoidance, sense of hopelessness, and crying episodes. The California MTUS guidelines indicate that behavioral interventions are recommended, stating that the identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy. Guidelines for cognitive behavioral therapy for chronic pain include screening for patients with risk factors for delayed recovery including fear avoidance beliefs. The initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach. Separate cognitive behavioral psychotherapy should be considered after 4 weeks if lack of progress from physical medicine alone, with an initial trial of 3-4 psychotherapy visits. A total of up to 6-10 individual sessions may be approved with evidence of objective functional improvement. The injured worker did report feelings of insecurity, fears of dying, health worries, social apprehension, and lack of concentration. Objective findings indicated a Beck Anxiety Inventory score of 38, Beck Depression Inventory score of 23, and Pain Catastrophizing Scale of 43. Past treatments included behavioral pain management therapy and an unknown number of individual and group psychotherapy sessions; however, the documentation does not indicate how many sessions the injured worker has completed. There is a lack of documentation indicating the injured worker has had decreased psychological pathology as a result of cognitive behavioral therapy. Therefore at this time, the request for six cognitive behavioral therapy sessions is found to be not medically necessary.