

<b>Case Number:</b>	CM14-0011206		
<b>Date Assigned:</b>	02/24/2014	<b>Date of Injury:</b>	10/10/2007
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2014

### 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 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 is a 67-year-old female who has submitted a claim for lumbar spine strain with radicular complaints status post lumbar spine posterior decompression and L4-L5 fusion; and panic disorder with agoraphobia associated with an industrial injury date of October 10, 2007. Medical records from 2013-2014 were reviewed. The patient complained of intermittent moderate low back pain with radiation to the left leg. It was aggravated when lying on her left side. The patient also experiences sadness, depression, anxiety, panic attacks, episodes of crying, lack of sexual libido, irritability, and impairment with memory and concentration. Physical examination showed tenderness of the left paralumbar musculature as well as the left sciatic notch. There was limited range of motion of the lumbar spine. Muscle spasms were also noted. The patient reported period of sadness but these have lessened in frequency and intensity. Imaging studies were not available. Treatment to date has included medications, physical therapy, aqua therapy, home exercise program, and activity modification. Utilization review, dated January 16, 2014, denied the request for initial 4 psychiatric individual and group psychotherapy sessions including cognitive behavioral therapy because there was no clear rationale as to why group psychotherapy as well as individual psychotherapy was being requested, and there was lack of evidence as to if the patient benefited from the previous sessions. The request for initial 4 medication management sessions (one time in every three months) was also denied because there was no clear rationale provided to support it.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Initial four (4) psychiatric individual and group psychotherapy sessions including Cognitive Behavioral Modification (CBT): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavior interventions Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress Chapter, Group therapy.

**Decision rationale:** With regards to individual psychotherapy, CA MTUS Chronic Pain Medical Treatment Guidelines page 23 states that an initial trial of 3-4 psychotherapy visits over 2 weeks are recommended; and with evidence of objective functional improvement, total up to 6-10 visits over 5-6 weeks. For group psychotherapy, CA MTUS does not specifically address this issue. ODG states that group therapy is recommended in PTSD. With regards to cognitive behavior modification, CA MTUS Chronic Pain Medical Treatment Guidelines page 23 state that behavioral modifications are recommended for appropriately identified patients during treatment for chronic pain, to address psychological and cognitive function, and address co-morbid mood disorders. With evidence of objective functional improvement, a total of up to 6-10 visits. In this case, the patient was diagnosed to have panic disorder with agoraphobia. The patient suffers sadness, depression, anxiety, panic attacks, episodes of crying, lack of sexual libido, irritability, and impairment with memory and concentration. The patient has been having individual and group psychotherapy sessions since March 2013. The patient already had 10 visits of psychotherapy with noted functional improvement. The present request would exceed the recommended guidelines for the treatment. As for group psychotherapy, there is no documentation that patient suffers from PTSD. The medical necessity for group psychotherapy has not been established. Furthermore, the present request was for initial psychotherapy sessions but the patient is currently ongoing treatment. Therefore, the request for INITIAL FOUR (4) PSYCHIATRIC INDIVIDUAL AND GROUP PSYCHOTHERAPY SESSIONS INCLUDING COGNITIVE BEHAVIORAL MODIFICATION (CBT) is not medically necessary.

**Initial four (4) medication management sessions (one (1) time every three (3) months): 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), Pain Chapter, Office Visits.

**Decision rationale:** As stated on page 405 of the ACOEM Stress-related Conditions Guidelines referenced by CA MTUS, frequency of 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. These visits allow the physician and patient to reassess all aspects of the stress model (symptoms, demands, coping mechanisms, and other resources) and

to reinforce the patient's supports and positive coping mechanisms. Generally, patients with stress-related complaints can be followed-up by a midlevel practitioner every few days for counseling about coping mechanisms, medication use, activity modifications, and other concerns. ODG Pain chapter states that the determination of clinical office visit is based on what medications the patient is taking, since some medicines such as opiates, among others, require close monitoring. In this case, the patient was diagnosed with panic disorder with agoraphobia. A medication management is appropriate and necessary in order to establish and monitor the patient's medication regimen. However, the number of office visit is contingent to the patient's response. The benefits and improvement that the patient will derive from the requested number of sessions is uncertain at this time. Therefore, the request for INITIAL FOUR (4) MEDICATION MANAGEMENT SESSIONS (ONE (1) TIME EVERY THREE (3) MONTHS) is not medically necessary.