

Case Number:	CM14-0150848		
Date Assigned:	09/29/2014	Date of Injury:	12/19/2012
Decision Date:	10/27/2014	UR Denial Date:	08/29/2014
Priority:	Standard	Application Received:	09/16/2014

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 & Neurology, has a subspecialty in Addiction Medicine 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 144 pages of medical and administrative records. The injured worker is a 66 year old female whose date of injury is 12/19/2012 due to a slip and fall. Injuries were to the face, head, neck, and both arms. She subsequently developed an anxiety disorder. She has the diagnoses of brachial neuritis/radiculopathy and chronic pain syndrome. She had received 10 sessions of CBT and is now requesting additional sessions. Psychiatric evaluation on 04/24/14 diagnosed her with anxiety disorder not otherwise specified. A past evaluation diagnosed her with major depressive disorder. She was dysphoric and anxious. She has had continuing headache pain and difficulty with concentration and memory since her industrial injury. CBT progress notes show that her memory, judgment, attention/concentration were all intact. Affect varied from euthymic to dysphoric. Her somatic, pain, and functional complaints had decreased. Depression and anxiety were decreased. Tolerance for work functions/activities of daily living, and strength and endurance had increased. A progress note on 09/11/14 by [REDACTED] has the patient on Bupropion XL, and there was a plan to start buspirone after discontinuing Klonopin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive Behavioral therapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Psychological Treatment Page(s): 102.

Decision rationale: The patient has been diagnosed with anxiety and depressive disorders. She suffers from chronic pain related to her industrial injury. According to [REDACTED], the patient was to start on buspirone, an anxiolytic in the azapirone class (unrelated to benzodiazepines) used to treat anxiety disorders. The addition of this medication may very well ameliorate the patient's anxiety symptoms. There are no further reports to review regarding whether the patient received this medication and its efficacy. She is also on Wellbutrin XL, an antidepressant. She has received 10 certified CBT sessions, from which she has shown objective functional improvement. This is the totality of what is recommended in MTUS guidelines. In addition, this request does not specify number of sessions or over what time frame. Given all of the above factors, this request is noncertified. Per MTUS, psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments 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 following stepped-care approach to pain management that involves psychological intervention has been suggested: Step 1: 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 in how to screen for patients that may need early psychological intervention. Step 2: 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. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. Also per MTUS, the identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. See also Multi-disciplinary pain programs. ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these at risk patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone: - Initial trial of 3-4 psychotherapy visits over 2 weeks - With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions). Such as, Cognitive Behavioral therapy is not medically necessary.