

<b>Case Number:</b>	CM14-0157650		
<b>Date Assigned:</b>	09/30/2014	<b>Date of Injury:</b>	07/21/2009
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	08/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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 licensed in Clinical Psychology 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:

According to the records that were provided for this independent review, this patient is a 31-year-old female who reported an industrial/occupational injury that occurred during her normal work duties as a [REDACTED] on July 21, 2009. On the date of the injury she stated that she was working as a counseling secretary completing mass enrollments and her office space was ergonomically poor, resulting in her hands swelling and becoming painful because of the heavy data entry load. She was treated with physical therapy and medication for pain. She returned to work with restrictions and became aware in March 2010 that she may lose her job because of the restrictions. She experienced a significant degree of stress as a result. She continued conventional medical treatment for the next two years including chiropractor, physical therapist, psychology, and "electrical stimulation." She subsequently had two surgeries on her hand and had a stellate ganglion nerve block that resulted in facial paralysis and severe reaction that resulted in emergency room treatment. An emotional state of depression followed the ER and lasted for the next five months. The patient was diagnosed with Reflex Sympathetic Dystrophy Syndrome after the second surgery she returned to work in December 2012/2013 and attended therapy sessions (6 sessions between 2012 and 2014). She also had 10 sessions of group therapy in 2012 and she found the format of the treatment only to be of minimal help as it seemed like a lot of complaining to her. There were also nine sessions of individual therapy in 2012, when asked if the treatment was helpful she responded: "we are done" there was no mention of significant improvement or benefit from the sessions. She has been prescribed Cymbalta 60 mg a day. With regards to having further psychological/psychiatric treatment she said: "if it will help me I would be very open to it." She currently reports hand pain, nerve pain in the neck and headache with RSD flare-up. Psychologically, she reports irritability, depression, poor sleep, anger, low self-esteem, poor concentration and attention,

some social withdrawal that has improved, crying spells, apathy, sexual dysfunction, headaches. She reports no prior mental health problems or treatment before her injury. The patient had a comprehensive psychological evaluation that was conducted in July 2014. She was diagnosed with: Somatic Symptom Disorder with Predominant Pain; Adjustment Disorder with Anxiety and Depression. There are other conflicting diagnostic impressions do not include the Somatic Symptom Disorder but do include Cognitive Disorder Secondary to Complications of Stellate Ganglionic Block with Facial Paralysis; and Pain Disorder with Psychological Factors and a General Medical Condition. A Treatment recommendation was made for weekly individual psychotherapy sessions for three months and then twice per month sessions for an additional six months for a total of 24 sessions, along with a psychiatric evaluation and treatment. The requested treatment is to consist of cognitive behavioral therapy and relaxation training to decrease depression, anxiety, stress symptoms and increase self-care techniques and coping skills. The request was noncertified, with utilization review offering an initial trial of six sessions to determine the patient's response to treatment. This independent medical review will address request to overturn that decision.

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

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

**Psychotherapy x 24 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Part Two, Behavioral Interventions, Cognitive Behavioral Therapy Page(s): 23-24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, Topic Cognitive Behavioral Therapy, Psychotherapy Guidelines, June 2014.

**Decision rationale:** According to the MTUS treatment guidelines for chronic pain and psychotherapy, psychological treatment is a recommended intervention for appropriately identify patients during treatment for chronic pain. Psychological intervention for chronic pain include setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing comorbid mood disorders such as depression, anxiety, panic disorder, and posttraumatic stress disorder. An initial treatment trial of 3-4 psychotherapy visits over a two-week period should be offered (this can be up to a maximum of six sessions according to the ODG) and with evidence of objective functional improvement, a total of up to 6-10 visits every 5 to 6 week period of individual sessions can be offered. Additionally, the official disability guidelines further clarify that 13-20 sessions maximum may be offered progress in her treatment. This request is for 24 sessions which exceeds the maximum number of sessions allowed which are 20. In addition, the guidelines state that provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate. The request for 24 sessions ignores the need for an initial treatment trial, and it ignores the need for ongoing assessment of medical necessity that is defined in terms of objective functional improvements: increase in activities of daily living, decreased work

restrictions, and decreased reduction in dependency on future medical care. The utilization review rationale for non-certification did allow for the treatment to begin with six sessions as an initial treatment trial per MTUS guidelines. The request for 24 treatment sessions is not medically necessary based on the above stated reasons. Therefore, the request is not medically necessary.