

<b>Case Number:</b>	CM14-0021719		
<b>Date Assigned:</b>	02/24/2014	<b>Date of Injury:</b>	12/20/2007
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	12/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/10/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 49-year-old female who has submitted a claim for thoracic/lumbar intervertebral disc displacement, major depressive disorder, single moderate to severe, non-psychotic, industrial; and pain disorder associated with an industrial injury date of December 20, 2007. Medical records from 2012 through 2014 were reviewed, which showed that the patient complained of neck and low back pain accompanied by tingling stiffness, numbness and tenderness. She also has significant depression as a result of her medical symptoms. Examination of the shoulders revealed positive impingement sign, positive supraspinatus sign, AC joint tenderness, positive crepitus, negative drop arm test and negative sulcus sign. Tenderness over the paracervical, levator scapulae, medial trapezius and parascapular muscles was noted. Spurling sign was positive. Fabere test was positive bilaterally. Sensation was intact in both upper and lower extremities. Motor strength was 5/5 for bilateral upper and lower extremities. Treatment to date has included medications, steroid injections, physical therapy, and psychotherapy sessions. Utilization review from December 26, 2013 modified the request for cognitive behavioral psychotherapy once weekly for 24 weeks to cognitive behavioral psychotherapy once weekly for 6 weeks because the requested for 24 sessions was excessive. She has received psychotherapy and showed objective functional improvement however she continues to be symptomatic. She requires additional sessions to further stabilize her condition and consolidate the gain already made.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**COGNITIVE BEHAVIORAL PSYCHOTHERAPY 1 X WKLY X 24 WKS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, Behavioral Intervention, page(s) 23; Psychological Treatment, page 101 Page(s): 101.

**Decision rationale:** According to pages 23 and 101 of the CA MTUS Chronic Pain Medical Treatment Guidelines, behavioral modifications are recommended for appropriately identified patients during treatment for chronic pain to address psychological and cognitive function and address co-morbid mood disorder. The guidelines recommend an initial trial of 3-4 psychotherapy visits over 2 weeks and with evidence of functional improvement, a total of 6-10 visits over 5-6 weeks. In this case, medical records submitted for review show that the patient has previously attended psychological therapy. Previous UR dated 12/26/13 mentioned that she has attended at least 14 sessions and has showed improvement from them. However the present request of number of sessions exceeds guideline recommendations since the patient already completed 14 sessions. Furthermore, the previous UR done already approved an additional 6 visits. Therefore, the request for COGNITIVE BEHAVIORAL PSYCHOTHERAPY 1 X WKLY X 24 WKS is not medically necessary.