

<b>Case Number:</b>	CM14-0035103		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	11/12/2011
<b>Decision Date:</b>	07/18/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/21/2014

### 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; Addiction Medicine has a subspecialty in Geriatric 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:

Records reviewed include 304 pages of medical and administrative records. The injured worker is a 74 year old male whose date of injury is 11/12/11. His psychiatric diagnoses include depression not otherwise specified, anxiety disorder not otherwise specified, insomnia and stress related physiological response affecting headache. The patient was attempting to place an extension cord behind a stack of 10 tables. He fell back with the tables on top of him. Injuries sustained were to his knees, left arm and left shoulder. He was treated with physical therapy and medications, underwent left shoulder surgery in approximately April 2012, followed by additional physical, acupuncture and chiropractic therapy. He continued to have neck, left shoulder, and low back pain with numbness and tingling in the left lower extremities. He then became depressed with feelings of sadness, helplessness, tearfulness, difficulty sleeping, and decreased energy. He received authorization for 10 initial cognitive behavioral group visits on 11/18/13, which he attended weekly. A progress note of 12/16/13 stated that he found them helpful with mood and increasing social interaction, however no further documentation was provided. [REDACTED] performed a psychological evaluation on 01/24/14. The patient continued to experience headaches under stress. He reported continued anxiety and depression with improvement in psychological symptoms. He attested to feeling sad, afraid, nervous/tense, dizziness, decreased sexual desire, inability to enjoy usual activities, difficulty remembering and making decisions, and tearfulness. He recommended hypnotherapy for 12 weeks as a pain control method. Psychological testing was performed however no metrics were provided for review. Medications listed in orthopedics visits included Naproxen, Ondansetron, Levofloxacin, and Pantoprazole.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Additional Cognitive Behavioral Group Psychotherapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cognitive Behavioral Therapy 101-102.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment Page(s): 101-102 of 127.

**Decision rationale:** No documentation beyond [REDACTED]' psychological evaluation of January 2014 was provided for review. There are no standardized metrics/testing to show functional improvement or reassessment of the patient's reported symptoms. Number of sessions was not specified in this request. As such this request is noncertified. Per CA-MTUS, 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 have been found to be particularly effective. Psychological treatment 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.

### **Additional Hypnotherapy / Relaxation Training:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Mental Illness and Stress Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress; Hypnosis.

**Decision rationale:** The patient continued to report pain symptoms. There were no standardized metrics/testing provided showing the efficacy of hypnotherapy on the patient's pain level. It is also unknown how many sessions of hypnotherapy the patient has received to date. This request

is therefore not certified. CA-MTUS does not reference hypnotherapy, as such ODG was utilized in the formulation of this decision. Per ODG, hypnosis is a therapeutic intervention that may be an effective adjunctive procedure in the treatment of PTSD and may be used to alleviate PTSD symptoms such as pain, anxiety, dissociation, and nightmares, for which hypnosis has been successfully used. (VA/DoD, 2004) (Brom, 1989) (Sherman, 1998). Hypnosis is not a therapy per se, but an adjunct to psychodynamic, cognitive-behavioral, or other therapies, and has been shown to enhance significantly their efficacy for a variety of clinical conditions. Various meta-analyses of studies on the treatment of anxiety, pain, and other conditions imply that hypnosis can substantially enhance the effectiveness of psychodynamic and CBTs; however, most of the literature on the use of hypnosis for PTSD is based on service and case studies.