

<b>Case Number:</b>	CM14-0077096		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	05/31/2006
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	04/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/28/2014

### 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 a licensed Psychologist 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 claimant is a 59 year-old male (██████████) with a date of injury of 5/31/2006. The claimant sustained multiple injuries to his neck, low back, knee, ankle and groin when he fell approximately 20 feet from a ladder that was resting against some scaffolding. The claimant sustained these injuries while working for ██████████. In his 3/4/14 PR-r report, ██████████ diagnosed the claimant with (1) Fracture shaft fibula; (2) Sprain/strain of ankle; and (3) Pain in joint ankle/foot. Additionally, in his Primary Treating Physician's Initial Report and Review of Medical Records dated 3/12/14, ██████████ diagnosed the claimant with: (1) Status post C3-4 and C4-5 ACDF with residuals with bilateral upper extremity radiculopathy; (2) Status post L5-S1 ALIF with left lower extremity radiculopathy residual; (3) Bilateral knee internal derangement; and (4) Bilateral knee internal derangement. It is also reported that the claimant developed psychiatric symptoms secondary to his work-related orthopedic injuries. In the RFA dated 4/23/14, Psychological Assistant, ██████████, and supervising Psychologist, ██████████, diagnosed the claimant with: (1) Major depressive disorder, single episode; (2) Anxiety disorder, NOS (not otherwise specified); (3) Male Hypoactive sexual desire disorder; and (4) Sleep disorder, insomnia type. The claimant has been treated for his psychiatric/psychological diagnoses with psychotropic medications and individual/group psychotherapy with relaxation/hypnotherapy sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prospective request for 6 weekly cognitive behavioral group psychotherapy sessions:**  
Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision on the Non-MTUS Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, Cognitive therapy for depression and the Other Medical Treatment Guideline or Medical Evidence: The American Psychiatric Association Practice Guideline for the Treatment of Patients with Major Depressive Disorder (2010) (pgs. 48-49 of 118).

**Decision rationale:** Based on the review of the vast medical records, the claimant has been receiving psychological and psychiatric services for a couple of years. The most recent Requested Progress Report dated 4/21/14 from [REDACTED] and [REDACTED] does not provide any information about the types of services being offered as well as the number of services completed. In regards to progress from the completed services, it is reported that the patient has made some progress toward current treatment goals as evidenced by: the patient reports of improved mood, ability to relax and social functioning with treatment. The treatment goals outlined remain fairly the same from report to report. They are listed as: Decrease frequency and intensity of depressive symptoms; Improve duration and quality of sleep; Decrease frequency and intensity of anxious symptoms; and Patient will increase levels of motivation and hopefulness. It appears that the claimant continues to experience symptoms of depression and anxiety despite the amount of therapy that he has received over the years. It also appears that the treatment plan goals and interventions tend to remain the same from month to month despite the lack of consistent progress. Given this information, the request for additional group psychotherapy sessions weekly appears excessive and not reasonable. As a result, the prospective request for 6 weekly cognitive behavioral group psychotherapy sessions is not medically necessary. It is noted that the claimant received a modified authorization for 5 cognitive behavioral group psychotherapy sessions in response to this request.

**Prospective request for 6 weekly relaxation training/hypnotherapy sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 400, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398-404.

**Decision rationale:** Based on the review of the vast medical records, the claimant has been receiving psychological and psychiatric services for a couple of years. The most recent Requested Progress Report dated 4/21/14 from [REDACTED] and [REDACTED] does not provide any information about the types of services being offered as well as the number of services completed. In regards to progress from the completed services, it is reported that the Patient has made some progress toward current treatment goals as evidenced by: the patient reports of improved mood, ability to relax and social functioning with treatment. The treatment goals outlined remain fairly the same from report to report. They are listed as: Decrease frequency and intensity of depressive symptoms; Improve duration and quality of sleep; Decrease frequency and intensity of anxious symptoms; and Patient will increase levels of motivation and hopefulness. It appears that the claimant continues to experience symptoms of

depression and anxiety despite the amount of therapy that he has received over the years. It also appears that the treatment plan goals and interventions tend to remain the same from month to month despite the lack of consistent progress. Given this information, the request for additional relaxation/hypnotherapy sessions weekly appears excessive and not reasonable. As a result, the prospective request for 6 weekly relaxation training/hypnotherapy sessions is not medically necessary.