

<b>Case Number:</b>	CM14-0187684		
<b>Date Assigned:</b>	11/17/2014	<b>Date of Injury:</b>	02/13/2003
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	10/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2014

### 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 809 pages of medical and administrative records. The injured worker is a 51 year old female whose date of injury is 02/13/2003 involving her neck, right shoulder, lower back, and right leg. She had bent down to go underneath a conveyor belt, hit her head and fell onto her right hand and right buttock resulting in neck and right shoulder pain. After a few days she developed right lower back and right leg pain. There was no loss of consciousness. An AME of 04/20/12 reports that she was declared permanent and stationary on 09/10/03. She continued working until 01/05, but not since. She has undergone several right shoulder surgeries followed by PT, with some improvement. She also received injections, acupuncture, and pain management. She had continuing headaches and was declared to be no longer permanent and stationary. She began to see a counselor weekly which was helpful, but not significantly. She had worsening depression and anxiety, with antidepressants and anti-anxiety meds frequently changing due to side effects that she found intolerable. She had received a total of 20 psychotherapy visits by 03/27/12. Her diagnoses were depressive disorder not otherwise specified, psychological factors affecting medical disorder, and chronic pain disorder. Psychiatric evaluation of 06/19/13 indicated that the patient had difficulty with attention, concentration, had initial and terminal insomnia, was unable to do previous activities, had spontaneous crying spells and was increasingly more anxious, irritable and paranoid. She had passive suicidal ideation without intent. She had chronic pain in the back, neck, and shoulders. On 11/05/13 six CBT sessions were certified. On 12/31/13 a psychological update reports that the patient stated her anxiety started to decrease since starting therapy. She had completed the 6 certified sessions (for a total of 26 CBT sessions). Plan involved reducing depressive symptoms, reduce guilt, encourage connecting with others, and increase empowering beliefs. 05/19/14

psychiatric report showed that on Seroquel XR 50mg she felt fatigued and hangover feared that something would happen, heard voices that made her afraid, and felt unimproved. She denied self-harm thoughts. She continued to receive management of chronic neck, low back, and shoulder pain with Norco. On 08/04/14 Seroquel was changed to Trazodone 50mg for sleep disturbance. Pain management follow up of 10/14/14 indicated continuing chronic neck pain, cervical degenerative disk disease, chronic low back, lumbosacral degenerative disk disease, tension headaches, myofascial pain syndrome, and bilateral shoulder pain. She was on Norco. Psychiatry follow up on 10/17/14 showed the patient as anxious, irritable, very depressed, withdrawn, feels helpless and hopeless, lacking motivation or desire to do much. She had sleep disruption and poor appetite with weight loss. She reported crying spells. Anxiety and panic attacks had increased in frequency. Current medications of Brintellix, Trazodone, and Wellbutrin XL were helping to some extent.

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

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

#### **Cognitive Behavioral Therapy sessions #6: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain(Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23.

**Decision rationale:** The injured worker continues to show depression, anxiety and sleep disruption which is responding minimally to medications. She has undergone several surgeries and other treatments, which have provided some relief but she continues to suffer from chronic pain. She has already received a total of 26 CBT sessions to date, the last being 12/31/13. While initially she received some improvement which was described as not significant, by the end of the certification she reported that her anxiety was decreasing. She is currently experiencing worsening anxiety and depressive symptoms, has not done well with physical medicine, and has had delayed recovery. Allowing her an additional trial of CBT, in conjunction with what is now a stable medication regimen would be worthwhile at this juncture. According to CA-MTUS 2009 Medical Treatment Utilization Schedule, Chronic Pain Medical Treatment Guidelines: 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. According to 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). Therefore, the request for Cognitive Behavioral Therapy sessions #6 is medically necessary and appropriate.