

<b>Case Number:</b>	CM14-0190514		
<b>Date Assigned:</b>	11/24/2014	<b>Date of Injury:</b>	04/06/1992
<b>Decision Date:</b>	01/16/2015	<b>UR Denial Date:</b>	10/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2014

### 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 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 provided records, this patient is a 68 year old female who reported a work-related injury that occurred on April 6, 1992 during the course of her employment as an office manager for [REDACTED]. The injury occurred when a 30 pound stack of food boxes fell onto her neck, mid back, low back with acute onset of neck, low back and right lateral elbow pain. Medically, a partial list of her diagnoses includes: lumbar disc degeneration without myelopathy; cervical disc displacement without myelopathy. She was declared permanent and stationary March 2, 1993 with continued signs and symptoms of cervical radiculopathy. She reports ongoing chronic neck pain that radiates to the lower upper extremity, ongoing low back pain with radiation, right lateral elbow pain with limited range of motion. This IMR will address the patient psychological symptomology as it relates to the current requested treatment. There is a notation in the medical records that she underwent psychiatric treatment and efforts to learn coping skills in 1997, it is not clear whether or not she had prior psychological treatment. According to a note from February 13, 2014 she was evaluated for a functional restoration program and found to be a good candidate. A treatment note from March 28, 2014 states that the patient would like to participate in the functional restoration program but is having difficulty with external commitments helping service dogs and is going through a divorce which made it difficult for her to attend but that she states that she would try to adjust her schedule. It is not clear whether or not she participated in that program. A progress note from her primary treating physician from March 28, 2014 states quote the patient denies anxiety, depression, hallucinations or suicidal thoughts." Psychologically, she's been diagnosed with the following: Pain Disorder Associated with Both a General Medical Condition and Psychological Factors; Depressive Disorder NOS; Anxiety Disorder NOS. She reports that her chronic pain symptoms have impacted her ability to perform activities of daily living such as housework, hobbies, ambulation,

and she reports symptoms of depression and states that her pain makes her more emotional and sad and increases family stress which eventually contributed to the ending of her marriage. She reports social isolation, and anxiety and sleep disturbance. A primary physician treatment progress note from May 20, 2014 states patient is having depression due to the passing of a close friend and a service dog psychiatric status states patient complains of depression but denies anxiety, hallucinations and suicidal thoughts. A treatment note from August 11 2014 repeats the same psychological status. There is an additional notation that she does not wish to start antidepressant medication. A request was made for 12 follow-up visits with a psychologist, the request was non-certified; this IMR will address a 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:

#### **12 follow up visits with a psychologist: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405, Chronic Pain Treatment Guidelines part 2, behavioral interventions, cognitive behavioral therapy.

**Decision rationale:** The American College of Occupational and Environmental Medicine (ACOEM) guidelines state that the frequency of follow visits may be determined by the severity of symptoms, whether the patient was referred for further testing and/or psychotherapy, and whether the patient is missing work. These results allow the physician and patient to reassess all aspects of the stress model (symptoms, demands, coping mechanisms, and other resources) and to reinforce the patient's supports and positive coping mechanisms. Generally, patients with stress-related complaints can be followed by a mid-level practitioner every few days for counseling about coping mechanisms, medication use, activity modification, and other concerns. These interactions may be conducted either on site or by telephone to avoid interfering with modified for full duty work if the patient has returned to work. Followed by a physician can occur when a change in duty status is anticipated (modified, increased, or forward duty) at least once a week if the patient is missing work. According to the California MTUS treatment guidelines, psychological treatment is 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 functioning, and addressing comorbid mood disorders such as depression, anxiety, panic disorder, and Post-traumatic Stress Disorder (PTSD). The identification and reinforcement of coping skills is often more useful in the treatment of chronic pain and ongoing medication or therapy which could lead to psychological or physical dependence. An initial treatment trial is recommended consisting of 3-4 sessions to determine if the patient responds with evidence of measureable/objective functional improvements. Guidance for additional sessions is a total of up to 6-10 visits over a 5 to 6 week period of individual sessions. With regards to the requested treatment, the medical necessity of the request was not established by the documentation provided for this review. The patient's

injury occurred over 22 years ago, and there are several mentions of prior psychological/psychiatric care and yet no detailed discussion of her prior psychological/psychiatric treatments have been provided for consideration of this current requested treatment. It is unclear how much prior psychological care she has received, and how much benefit, if any, was derived from any provided psychological treatment. The patient was approved for a functional restoration program over 6 months ago and it remains unclear whether or not she did participate in the program. This request is for 12 sessions of therapy. If this is a request to start a brand-new course of psychological treatment, the California MTUS guidelines specifically state that an initial block of 3 to 4 sessions to be provided. If this is a request to continue in an ongoing already in progress course of treatment then additional information regarding the patient's response to prior treatment is required. It would also need to be known whether or not the total number of sessions that she has received conforms to the above stated guidelines which suggest a maximum of 6-10 visits. The request for 12 sessions exceeds guidelines and does not follow this protocol. No specific treatment plan was discussed with regards to the requested follow visits with specific goals and expected dates of accomplishment. Psychological care is contingent not only upon the patient exhibiting significant psychological symptomatology but also efficacy of prior treatments which includes objectively measured functional improvements. This was not provided. Because of these reasons, the medical necessity was not established.