

<b>Case Number:</b>	CM14-0192604		
<b>Date Assigned:</b>	11/26/2014	<b>Date of Injury:</b>	07/15/2000
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	11/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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 and Addiction Medicine, has a subspecialty in Geriatric Psychiatry and is licensed to practice in California and Texas. 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 injured worker is a 44 year old male whose date of injury is 07/15/2000, in the course of his occupation as a salesman. The primary diagnosis is bipolar disorder, manic severe, with psychotic features. He stepped out of a motor home when his right foot became caught, causing him to trip and twist his right knee. Subsequent to this he has sustained multiple falls causing injury to multiple body parts. He was treated with injections, and multiple surgeries. He received physical therapy and pain management. He developed depression and anxiety, then was diagnosed with bipolar disorder around 2003-2004. He received psychotherapy and medication management. On 08/15/14 the patient was noted to have completed seven of eight psychotherapy sessions certified. A UR of 09/19/14 indicated that the patient has had ongoing psychotherapy since 11/2001, has exceeded guidelines for recommended number of sessions, and has remained depressed and anxious without evidence of objective functional improvement. On 10/14/14 the patient's BMI was 31.6 (5'6", weight 196 lbs.). On 10/15/14 [REDACTED], DO reported that the patient experienced panic attacks even when sleeping. Medications included Lithium, lorazepam, Tegretol XR, Paxil, Paxil CR, Ambien CR, Nexium, and olanzapine. Mood was sad/depressed, affect blunted and restricted in range. In a PR2 of 10/31/14 by [REDACTED], [REDACTED], the patient presented with high levels of neck pain and increased panic attacks. His diagnoses were bipolar disorder and anxiety disorder due to general medical condition (pain). His medications had not been authorized, leading to an eight day inpatient hospitalization. He was restarted on medications. He had a home program of pain management and sleep CD's supplied by [REDACTED]. He was working on losing weight. [REDACTED] was requested and denied. On 11/11/14 [REDACTED] noted that the patient had tried and failed Atkins, low carb intake, six small meals per day, and calorie counting. The patient's physical

limitations prevented him from all but minimal exercise, and the evaluation was recommended as the psychologist is unable to prescribe weight loss medications. It is unclear in any of the records provided whether or not the patient was or is on any pain medication.

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

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

#### **4 individual psychotherapy sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Cognitive Behavioral Therapy (CBT) Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 102.

**Decision rationale:** The patient had been in ongoing psychotherapy since at least 2001, placing him well beyond California MTUS/ Official Disability Guidelines (ODG. From records provided, there does not appear to be objective functional improvement in the patient's symptoms as he continues to suffer from depression, anxiety, and panic attacks. He received certification for an additional trial of eight sessions, completing seven of these by 08/15/14, again, with no evidence of objective functional improvement. Without showing improvement after this period of time, psychotherapy would not be indicated. This request is therefore noncertified. Individual psychotherapy sessions are 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 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. See also Multi-disciplinary pain programs. ODG Psychotherapy Guidelines:- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made. The request is not medically necessary and appropriate.

#### **4 biofeedback sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Biofeedback Page(s): 24-25.

**Decision rationale:** The California-MTUS 2009 Chronic Pain Medical Treatment Guidelines states the following in regards to: Biofeedback Not recommended as a stand-alone treatment, but recommended as an option in a cognitive behavioral therapy (CBT) program to facilitate exercise therapy and return to activity. There is fairly good evidence that biofeedback helps in back muscle strengthening, but evidence is insufficient to demonstrate the effectiveness of biofeedback for treatment of chronic pain. Biofeedback may be approved if it facilitates entry into a CBT treatment program, where there is strong evidence of success. As with yoga, since outcomes from biofeedback are very dependent on the highly motivated self-disciplined patient, we recommend approval only when requested by such a patient, but not adoption for use by any patient. EMG biofeedback may be used as part of a behavioral treatment program, with the assumption that the ability to reduce muscle tension will be improved through feedback of data regarding degree of muscle tension to the subject. The potential benefits of biofeedback include pain reduction because the patient may gain a feeling that he is in control and pain is a manageable symptom. Biofeedback techniques are likely to use surface EMG feedback so the patient learns to control the degree of muscle contraction. The available evidence does not clearly show whether biofeedback's effects exceed nonspecific placebo effects. It is also unclear whether biofeedback adds to the effectiveness of relaxation training alone. The application of biofeedback to patients with complex regional pain syndrome (CRPS) is not well researched. However, based on CRPS symptomology, temperature or skin conductance feedback modalities may be of particular interest. (Keefe, 1981) (Nouwen, 1983) (Bush, 1985) (Croce, 1986) (Stuckey, 1986) (Asfour, 1990) (Altmaier, 1992) (Flor, 1993) (Newton-John, 1995) (Spence, 1995) (Vlaeyen, 1995) (NIH-JAMA, 1996) (van Tulder, 1997) (Buckelew, 1998) (Hasenbring, 1999) (Dursun, 2001) (van Santen, 2002) (Astin, 2002) (State, 2002) (BlueCross BlueShield, 2004) This recent report on 11 chronic whiplash patients found that, after 4 weeks of myofeedback training, there was a trend for decreased disability in 36% of the patients. The authors recommended a randomized-controlled trial to further explore the effects of myofeedback training. (Voerman, 2006). See also cognitive behavioral therapy (Psychological treatment). ODG biofeedback therapy guidelines: Screen for patients with risk factors for delayed recovery, as well as motivation to comply with a treatment regimen that requires self-discipline. Initial therapy for these "at risk" patients should be physical medicine exercise instruction, using a cognitive motivational approach to PT Possibly consider biofeedback referral in conjunction with CBT after 4 weeks: - 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)- Patients may continue biofeedback exercises at home The request is not medically necessary and appropriate.

**Pain management group sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

**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, Group Therapy

**Decision rationale:** The patient does not carry the diagnosis of PTSD, and guidelines state that group therapy visits should be contained within the total number of psychotherapy visits. Psychotherapy, as noted above, is not indicated in this patient. It is unclear from records provided what pain medication, if any, the patient is being prescribed and whether or not he is receiving any other treatment for his pain (e.g. physical therapy). The request is not medically necessary and appropriate. California-MTUS does not address group sessions. ODG was used in this decision. Group therapy is recommended as an option. Group therapy should provide a supportive environment in which a patient with Post-traumatic stress disorder (PTSD) may participate in therapy with other PTSD patients. While group treatment should be considered for patients with PTSD (Donovan, 2001) (Foy, 2000) (Rogers, 1999), current findings do not favor any particular type of group therapy over other types. (Foy, 2000) See also PTSD psychotherapy interventions. Number of visits should be contained within the total number of Psychotherapy visits. The request is not medically necessary and appropriate.

**medical hypnotherapy sessions:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress

**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:** Per Official Disability Guidelines (ODG), hypnotherapy may be effective in posttraumatic Stress Disorder (PTSD) (and irritable bowel syndrome, neither of which apply to this patient. Hypnotherapy is an adjunct to psychotherapy and is not a treatment per se. Sessions should be contained within the total number of psychotherapy visits. The request is not medically necessary and appropriate. California-MTUS does not reference hypnotherapy. ODG was used in this decision. 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). In a study testing the effect of hypnosis on irritable bowel syndrome (IBS), it was found that the hypnosis was effective in reducing psychological distress and as a result, the IBS symptoms improved substantially, despite there being no measured physiological change. More testing should be done to measure the effect of hypnosis on stress reduction, with or without physical ailment, as preliminary results are positive. (Palsson, 2002) According to one meta-analysis, hypnotherapy is highly effective for

patients with refractory IBS, but definite efficacy of hypnosis in the treatment of IBS remain unclear (Gholamrezaei, 2006) 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. In the specific context of post-traumatic symptomatology, hypnotic techniques have been used for the psychological treatment of shell shock, battle fatigue, traumatic neuroses, and more recently, PTSD, and dissociative symptomatology. Hypnosis is defined by the APA as "a procedure during which a health professional or researcher suggests that a client, patient, or subject experience changes in sensations, perceptions, thought, or behavior." The hypnotic context is generally established by an induction procedure. An induction procedure typically entails instructions to disregard extraneous concerns and focus on the experiences and behaviors that the therapist suggests or that may arise spontaneously. Most of the case studies that reported that hypnosis was useful in treating post-trauma disturbances following a variety of traumas lack methodological rigor, and therefore strong conclusions about the efficacy of hypnosis to treat PTSD cannot be drawn. 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. Hypnotic techniques have been reported to be effective for symptoms often associated with PTSD such as pain, anxiety and repetitive nightmares. (VA/DoD, 2004)Criteria for the use of Hypnosis:Providers: Hypnosis should only be used by credentialed health care professionals, who are properly trained in the clinical use of hypnosis and are working within the areas of their professional expertise.Indications: There are a number of indications for using hypnosis in the treatment of PTSD: (1) Hypnotic techniques may be especially valuable for symptoms often associated with PTSD, such as dissociation and nightmares, for which they have been successfully used; (2) PTSD patients who manifest at least moderate hypnotizability may benefit from the addition of hypnotic techniques to their treatment; (3) Because confronting traumatic memories may be very difficult for some PTSD patients, hypnotic techniques may provide them with a means to modulate the emotional and cognitive distance from such memories as they are worked through therapeutically.Contraindications: There are a number of contraindications for using traditional hypnotic techniques in the treatment of PTSD: (1) In the rare cases of individuals who are refractory or minimally responsive to suggestions, hypnotic techniques may not be the best choice, because there is some evidence that hypnotizability is related to treatment outcome efficacy; (2) Some PTSD patients may be reluctant to undergo hypnosis, either because of religious belief or other reasons. If the resistance is not cleared after dispelling mistaken assumptions, other suggestive techniques can be tried, including emotional self-regulation therapy (ESRT), which is done with open eyes and uses sensory recall exercises rather than a hypnotic induction; (3) For patients who have low blood pressure or are prone to fall asleep, hypnotic procedures such as "alert hand," which emphasize alertness and activity rather than relaxation, may be substituted.Sessions: Number of visits should be contained within the total number of Psychotherapy visits.ODG indicates that hypnotherapy is an effective adjunctive procedure in the treatment of PTSD and may be used to alleviate PTSD symptoms such as pain, anxiety, dissociation, and nightmares, and reduce IBS symptoms due to reducing psychological distress. ODG also indicates that hypnotherapy 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. The patient does not have the diagnosis of PTSD, and she is not receiving psychotherapy with which to use hypnotherapy in

conjunction with. Number of visits should be contained within the total number of Psychotherapy visits. The request is not medically necessary and appropriate.

**1 weight management session:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pharmacologic and surgical management of obesity in primary care: a clinical practice guideline from the American College of Physicians. Ann Intern Med 2005 Apr 5;142(7):525-31

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Obesity, Hamby O et al. emedicine.medscape.com, Sep 15, 2014.

**Decision rationale:** On 10/14/14 the patient's body mass index (BMI) was 31.6. Per [REDACTED], the patient had tried and failed multiple approaches to weight loss. He suffers from physical limitations which impede his ability to exercise. His psychologist is unable to prescribe weight loss medications. One weight management session between 10/31/2014 and 01/06/2015 was certified on 11/18/2014 in UR #3009906. Records reviewed do not reflect use of that session. While this is a reasonable and in fact medically prudent request, until such time as updated records are provided, the request is not medically necessary and appropriate. California-MTUS, American College of Occupational and Environmental Medicine (ACOEM), and Official Disability Guidelines (ODG) were all researched. None reference obesity or weight management. Obesity is considered to be a BMI of 30-39.9. There are many comorbidities associated with obesity, e.g. cardiovascular, obstructive sleep apnea, Type 2 diabetes, reduced mobility. Evaluation by a physician is essential to determine if any medical conditions are present requiring treatment, what may be prevented, and to evaluate how best to approach and manage obesity. The etiology of obesity is complex, ranging from metabolic and genetic, to psychological and dietary factors. Studies have shown that people who were given the formal diagnosis of overweight/obese by a healthcare professional showed a higher rate of dietary change and/or physical activity. In consultation the patient can receive a full work up by a physician with education and counseling as to goals. Treatment of obesity includes weight loss programs, medication therapy, and bariatric surgery. The request is not medically necessary and appropriate.