

<b>Case Number:</b>	CM14-0194268		
<b>Date Assigned:</b>	12/02/2014	<b>Date of Injury:</b>	07/30/2003
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/20/2014

### 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 licensed 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:

This 47 year old man sustained an industrial injury on 7/30/2003 including a 12 foot fall resulting very severe physical trauma, including a closed head injury, fracture of C6-C7 resulting in incomplete quadriplegia. The injury occurred when he was standing in between 2 beams and fell requiring hospitalization for several months. He continues to have neck pain, low back pain, headache, memory difficulties bowel and bladder problems and multiple other severe physical problems. He is status post cervical fusion C-5 to T 2. Prior treatment has included epidural block, joint injection, CT scan of the cervical spine and head, skull x-ray, psychotherapy, physical therapy, and surgical intervention. This IMR is focused on the patient's psychological symptomology as it relates to the current requested treatment. Psychological diagnoses include: Pain Disorder Associated with Both Psychological Factors and a General Medical Condition; Anxiety Disorder Not Otherwise Specified; and Major Depressive Disorder, Recurrent, Moderate Symptoms. A treatment notes on 4/24/2014 state that he requires aggressive psychological and psychiatric care and on 6/12/2014 state that without such care, the worker will continue to deteriorate emotionally and become an imminent danger to himself, otherwise physical exam is as expected. A psychological PR-2 report indicates that the patient was seen 14 times between November 26, 2013 and April 16, 2014. There is no information regarding psychological treatment prior to November 2013, no comprehensive psychological evaluations were provided for consideration. He is noted to be depressed due to inability to provide for his family and experiences "nightmares, helplessness, fear, anhedonia, insomnia, low self-worth, concentration problems, diminished libido, irritability, and other symptoms of anxiety and depression including suicidal ideation. There is no discussion of patient progress in treatment nor is there any indication of specific treatment goals with dates of expected accomplishment. A psychiatric progress note from 10/28/2014 states that the worker is not doing well, states he is very anxious,

irritable, agitated, and frustrated that he has lost service with his therapist due to transportation not being approved. This note continues to state that he requires ongoing psychiatric care. On 11/3/2013, Utilization Review evaluated a request for cognitive behavioral therapy once per week for 12 weeks (12 total visits). The physician noted that there is no documentation of clinically meaningful objective functional improvement after receiving an excessive number of treatments. The request was denied and subsequently appealed to Independent Medical Review.

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

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

**Cognitive behavioral therapy once a week for 12 weeks (12 total visits) with Jorge Barragan:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines part 2, behavioral interventions, cognitive behavioral therapy Page(s): 23-24.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress chapter, topic: cognitive behavioral therapy, psychotherapy guidelines, November 2014 update

**Decision rationale:** According to the 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 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 recommend 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. The official disability guidelines (ODG) allows for a more extended treatment. According to the ODG studies show that an initial treatment trial of 4 to 6 sessions should be sufficient to provide symptom improvement but functioning and quality-of-life indices do not change as markedly within a short duration of psychotherapy as do symptom-based outcome measures. ODG psychotherapy guidelines: up to 13-20 visits over a 7-20 weeks (individual sessions) if progress is being made. The provider should evaluate symptom improvement during the process so that treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate. In some cases of Severe Major Depression or PTSD up to 50 sessions, if progress is being made. With regards to the requested treatment for 12 additional sessions of cognitive behavioral therapy to be held one time per week, the request is not substantiated as being medically necessary by the documentation provided for this review. Clinical information presented, in particular treatment related, was very limited. There were no individual treatment session progress notes, no comprehensive treatment plan with objectively measurable goals and expected dates of accomplishment, there was no indication the total quantity of sessions/duration of treatment provided to date, and no objectively measured indices

or data documenting patient improvement or any subjective reports of patient improvement as a result of prior treatment. The documentation provided was insufficient to demonstrate that the patient is improving as a result of continued psychological care, it may be that he is, but there was not any documentation supporting it if so. Continued psychological care is contingent upon not only significant patient symptomology but also documentation of patient benefit that includes objective functional improvements. In addition, the total duration and treatment session quantity is unknown. There was one indication that the patient has received 42 sessions to date, this was provided by the utilization review determination for non-certification. This may be inaccurate given the duration of the patient's injury, it is not what period of time this refers to. This information would be needed to determine whether or not the patient is eligible for additional care. As mentioned above, the official disability guidelines suggest that most patients the recommendation would be 13-20 sessions, but in cases of severe depression or PTSD up to 50 if treatment progress is being made. It is unclear whether or not the patient meets those guidelines which are reserved for most severe cases. Given the patient's severity of injury and psychological symptomology as reported by his treating Psychologist and Psychiatrist he may be eligible for extended treatment, based on his symptomology but it appears he has likely already exceeded it. The guidelines for continued psychological care were not established, therefore medical necessity was not established, and the utilization review determination for non-certification is upheld.