

Case Number:	CM14-0201068		
Date Assigned:	12/11/2014	Date of Injury:	11/21/2005
Decision Date:	01/28/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	12/02/2014

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 Psychologist (PHD, PSYD), 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 records made available for review, this is a 41-year-old male with a date of injury on 11/21/2005. Documentation from 07/10/2014 indicated that the injured worker fell off of a ladder from approximately twelve to fifteen feet high subsequently sustaining injuries to the neck, lower back, and right ankle. Documentation from 10/29/2014 indicated the diagnoses of chronic pain syndrome, chronic lumbar radiculopathy, lumbar post laminectomy syndrome, cervical radiculopathy, myofascial dysfunction, disuse syndrome, moderate obesity, and hemorrhoids. Physician evaluation from 09/22/2014 also noted the diagnoses of mild single episode of major depressive disorder, generalized anxiety disorder, and hypoactive sexual desire disorder due to chronic pain. Subjective findings from 10/29/2014 noted a pain level of five out of ten with increasing lower back pain, fatigue, and chronic gastrointestinal upset. Physical examination from the same date noted a flat affect, myofascial triggers at bilateral paravertebral lumbar four and lumbar five that were less, positive straight leg raise bilaterally at sixty degrees, and a decrease in sensation to the bilateral posterior thighs at lumbar five. Range of motion was documented as 45 degrees flexion, 10 degrees extension, 10 degrees right lateral, and 15 degrees left lateral. Psychology report from 09/22/2014 noted subjective findings of difficulty sleeping, communicating, making decisions, controlling emotions and impulses, social isolation, and withdrawn, along with feelings of sadness with crying spells, helplessness, tired, irritable, fearful, nervousness, restlessness, anxious, headaches, nightmares, sweaty palms and body sweats, and depressed with low energy. Examination from this date noted the injured worker to be in a sad, anxious mood, restless, apprehensive, with body tension, and was over talkative. Documentation from 07/10/2014 also indicated chipping of the injured worker's teeth secondary to clenching and grinding of the jaw. Medical records from 07/10/2014 noted previous diagnostic studies of electromyography with date unknown that was revealing for elevated facial

musculature activity with incoordination and aberrant function of the facial musculature. Diagnostic autonomic nervous system testing with unknown date was remarkable for increased sympathetic activity related to obstructions of the airway that was occurring during sleep. Prior treatments offered to the injured worker included use of a lumbar support, pool therapy, home exercise program, food diary, lumbar laminectomy, transcutaneous electrical nerve stimulation unit, six treatments of acupuncture, cognitive group psychotherapy, hypnotherapy/relaxation training, nocturnal obstructive airway oral appliance treatment, orthotic musculoskeletal trigeminal appliance, facial muscle reprogramming exercises, and a medication history of Butrans, Hydrocodone, Trazadone, Risperidone, Effexor, Prilosec, Voltaren, Ambien, Diclofenac, Cogentin, Haldol, and an unnamed patch. Documentation from 10/29/2014 noted an improvement in pain secondary to medication regimen, previous acupuncture treatments, and pool therapy. Medical records provided indicated that prior acupuncture treatments, pool therapy, cognitive group psychotherapy, and hypnotherapy/relaxation training was provided, but there was no documentation of quantity of visits (except for acupuncture visits), treatment plans, or results of the above listed treatments. The medical records provided did not indicate specific details of functional improvement, improvement in work function, or in activities of daily living. Documentation provided did not provide a specific work status. On 11/05/2014, Utilization Review non-certified the prescription of cognitive behavioral group psychotherapy one times a week for four months. Utilization Review noncertified based on ACOEM Guidelines, however the Utilization Review did not contain the explanation of why the request of cognitive behavioral group psychotherapy was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive behavioral group psychotherapy, once weekly for four months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 102.

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: Although the MTUS guidelines are non-specific for group cognitive behavioral therapy, the due address individual cognitive behavioral therapy treatment. 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 a 4 to 6 sessions trial 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. Pertaining to this requested treatment, 16 sessions of group cognitive behavioral therapy, the request does not conform to current treatment guidelines and therefore the medical necessity of the request is not established by the documentation provided. The total duration of this patient's psychological treatment and specifically the quantity of sessions already received was not clearly stated. According to the above stated guidelines for most patients a course of 13-20 visits over a 7 to 20 week period of individual sessions can be offered if progress is being made although the total number of previously provided sessions is not known, given that the request is for 16 sessions it almost certainly would exceed treatment guidelines assuming that the patient has had 4 or more prior sessions. In addition, the criteria that progress is being made in the treatment as evidenced by patient benefited which can include objective functional improvements such as increases in activities of daily living, reduction in dependency on future medical care, or reduction in work restrictions if applicable was not documented sufficiently to meet this criteria. Due to insufficient documentation of prior benefit, and quantity of sessions provided already, the medical necessity of the request for 16 sessions of group cognitive behavioral therapy is not evidenced as being medically necessary.