

Case Number:	CM14-0201972		
Date Assigned:	12/12/2014	Date of Injury:	11/18/2002
Decision Date:	01/30/2015	UR Denial Date:	11/17/2014
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 Board Certified 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 provided records, this patient is a 40-year old female who reported a work-related injury that occurred on November 18, 2002 during the course of her employment, the mechanism of injury was not specified for consideration. She has been diagnosed medically with Lumbar Disc Displacement without Myelopathy, lumbago, Sciatica, and Cervicobrachial Syndrome. She reports chronic low back pain with radiation into both lower extremities and has difficulty walking, standing and ambulation without assistant devices. She reports pain in both knees and trouble climbing stairs with additional neck pain radiating into both arms. This independent review will be focused on her psychological symptomology as they relate to the current requested treatment. She has been prescribed Zoloft and Xanax but has been having difficulty getting the Xanax authorized. She reports severe anxiety that she sometimes feels a desire to jump out of the window with shaking in her hands. She is having difficulty with the medication Zoloft stating that she feels like a zombie but has had side effects with 4 other antidepressant medications including Cymbalta, Prozac, Pamelor, and Effexor. She has been diagnosed psychologically with: Unspecified Major Depression, Single Episode; Panic Attacks; Pain Psychogenic NEC; and Unspecified Major Depression, Recurrent Episode. According to a psychological treatment progress note from June 2014 she is reporting social isolation, depressed mood and insomnia and passive suicidal ideation without plan or intention, treatment focus on the importance of self-care and being socially engaged and treating symptoms of anxiety and depression as they relate to the patient's work injury. There was no specific treatment plan with stated goals, expected dates of accomplishment, and objectively measured functional improvements were not provided. She was authorized for 6 sessions in June 2014. In a subsequent session she was tearful and discussed difficulty with denial of approval for medications. Treatment progress note from August 2014 she reports symptoms of severe

depression and feeling like a useless burden to her family. She was authorized for an additional 8 sessions that started on September 4, 2014. An additional treatment progress note from October 2014 has content that is nearly identical to the previously mentioned progress notes. A request was made for 6 additional follow-up visits with the psychologist, the request was non-certified by utilization review. This IMR will address a request to overturn that determination.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six additional follow-up visits with the psychologist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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 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. The official disability guidelines (ODG) allow 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. With regards to the request for an additional 6 follow-up sessions with the psychologist, the documentation provided does not establish the medical necessity of the request. Continued medical necessity for psychological treatment is contingent upon significant patient symptomology, evidence of substantial patient benefit from prior treatments that includes objective functional improvements, and that the total number of sessions provided conforms to the above stated guidelines. Although the provided documentation contained ongoing psychological treatment progress notes, these notes did not specify the cumulative total quantity of treatment sessions that have been provided to date, although they did mention the number of sessions relative to the authorization. According to the current treatment guidelines most patients are eligible for 13-20 visits with in some extraordinary situations of severe depression up to 50 visits if progress is being made. Because the total number sessions that the patient has received to date was not specified it was not possible to determine whether or not the number of sessions

that she is already been provided falls into these guidelines. In addition there was insufficient evidence of objective functional improvements in the records that were provided. There is mention of severe anxiety and yet no detailed information about how the treatment is impacting her depression/anxiety nor was there any information of what the specific treatment methodologies were being used to treat the depression/anxiety and her response to them. Progress notes spanned a period of time from June to October 2014 and there no mention of if/how the patient is benefiting from the treatment. There is no discussion of how much treatment she's had since the date of her injury which is well over a decade ago. Because of this the medical necessity of the request was not established, and because the medical necessity was not established the request of Six additional follow-up visits with the psychologist is not medically necessary.