

Case Number:	CM14-0202280		
Date Assigned:	12/09/2014	Date of Injury:	04/11/2002
Decision Date:	01/31/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	12/03/2014

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 medical records, this patient is a 62 year old female who reported a work-related injury that occurred on 04/11/2002 during the course of her employment for the [REDACTED]. The mechanism of injury was not provided in the medical records received. The patient's psychiatric diagnoses were not stated in the records provided. A hand-written psychiatric primary treating physician progress report from 11/18/2014 was only partially legible, it stated that she reports general stability but also anxiety episodes occasionally, continues to use 1 mg of Ativan and that anxiety levels and depression levels are stable/episodic. Mood is described as euthymic with no suicidal or homicidal ideation, Beck Depression Inventory scored 38 and Beck Anxiety Inventory score 19. Psychiatric medications include Topamax, Ativan, and Effexor. Her Beck Depression Inventory reflects significant depression as she states she feel sad much of the time and has feelings of hopelessness, pessimism, poor concentration, poor energy, excessive sleeping she reports having fears of the future and being able to care for herself. Self-disappointment and other signs of depression. I treatment progress note from 09/25/2014 the issue of progress made in treatment is left blank with no details provided. A prior treatment progress note from April 2014 states that even though her stressors have not been reduced or removed she has better control over her emotions for use of cognitive behavioral therapy and that continuing goal is to stabilize her emotions and improve functioning. At the time of the April progress note her Beck Depression Inventory score was 33 and Beck anxiety score was 13. A request was made for psychotherapy one time per week for 12 weeks, the request was non-certified. Utilization review rationale for non-certification was stated that "the patient has received extensive psychotherapy and is not shown much objective functional improvement continued psychotherapy is unlikely to be beneficial" 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:

Twelve sessions of Psychotherapy (1x12weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Behavioral Therapy; Mental illness

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines part 2, behavioral interventions, psychological treatment Page(s): 101-102; 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 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) 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. With respect to the current requested treatment, the documentation that was provided was insufficient to establish medical necessity of the requested procedure. There was insufficient information provided with respect to the patient's psychological treatment that she has had to date. The mechanism of her injury and how it resulted in psychological injury was not reported clear psychiatric diagnosis was not discussed or delineated. It is not clear how many sessions she has had or for how long of a period of time. Prior courses of psychological treatment since her date of injury in 2002 were not discussed. The outcome and benefit, if any, from the patient's prior psychological care was not discussed in a manner sufficiently to evidence of objective functional improvement or progress/benefit from prior treatment. Medical records regarding her psychological care submitted for this request consisted of approximately 46 pages with very few regarding her psychological treatment. No psychological comprehensive evaluation intake was provided. No comprehensive treatment plan for these additional sessions was provided specifying goals of treatment and expected estimated

dates of accomplishment. Although there was one mention in one progress report that the patient is benefiting from psychological treatment there was no discussion or details provided. Improvement was not quantified or discussed in any way. Beck Depression Inventory score comparison from the treatment notes in April to the ones provided for November 2014 reflect a worsening of condition. Because it is not known how many sessions she has had it is not clear whether or not she is already had the maximum suggested quantity. The patient may require additional psychotherapy, but if so this was not substantiated by the documents provided for this review. Because the medical records that were provided in sufficiently documented the medical necessity of the request, the medical necessity was not established. Because medical necessity was not established the request to overturn the utilization review is not approved.