

<b>Case Number:</b>	CM15-0001717		
<b>Date Assigned:</b>	01/12/2015	<b>Date of Injury:</b>	07/04/2014
<b>Decision Date:</b>	03/05/2015	<b>UR Denial Date:</b>	12/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Psychologist

### 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 July 4, 2014. Prior work related injury claims have been filed and resolved. She reports symptoms of depression and anxiety along with chronic radicular pain in her cervical spine and radicular symptoms in the upper extremities bilaterally. The injury reportedly occurred during the course of her employment as a Caregiver at [REDACTED] for Women when she was "punched with a fist on the left side of my neck." She remains symptomatic with pain -intermittent, exacerbated by movement that occurs on the left side of her neck. Her medical diagnoses include contusion, pain in neck cervicalgia, muscle spasm of neck, sprain/strain cervical. She reports headache symptoms that are exacerbated by stress, anxiety, increased neck pain and are decreased by rest, heat and medication. She reports having anxiety and stress moderate severity (as reported on 3/30/14) as a result of the altercation and wanted to approach psychological treatment for this reason. She received a psychological evaluation on August 13, 2014. She reports feeling anxious at work and fearful for her safety and that she was having difficulty concentrating, felt angry and afraid, and was "an emotional mess" when she left the scene of the attack she was driving home in her car and broke down crying. She has been diagnosed with the following psychological disorders: Depressive Disorder Not Otherwise Specified, Generalized Anxiety Disorder, Female hypoactive sexual desire disorder due to chronic pain, Insomnia Related to Anxiety Disorder Not Otherwise Specified in Chronic Pain, And Stress Related Physiological Response Affecting G.I. Disturbance, Headache. According to a treatment progress note from the treating psychologist (9-22-2014) she reports continued

anxiety but improved with treatment and still feel sad and nervous with crying spells and is restless and agitated with sleep difficulties. Treatment progress is described as "some improvement in managing emotional symptoms" treatment goals are noted to be the following: decrease frequency and intensity of depressive and anxious symptoms and improve duration and quality of sleep. According to a treatment progress note from November 3, 2014 the patient reports fearing the worst happening with intrusive recollections and flashbacks to her industrial injury and experiencing headache, distressing dreams, sweating sensations throughout her body with G.I. problems and difficulty with heartburn and indigestion but improved relationships. Session progress notes indicate patient reporting using skills learned in treatment to decrease anxiety levels. A request was made for 8 sessions of hypnotherapy/relaxation training one time a week for 8 weeks. The request was non-certified by utilization review. 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:

#### **8 Weekly Hypnotherapy/Relaxation Training 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 (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 400. Decision based on Non-MTUS Citation Mental illness and stress chapter, topic: hypnosis, December 2015 update

**Decision rationale:** The CA-MTUS guidelines are nonspecific for hypnosis, however the official disability guidelines does discuss the use of hypnosis and says that it is recommended as an option, a therapeutic intervention that may be an effective adjunct to procedure in the treatment of post-traumatic stress disorder PTSD. And hypnosis may be used to alleviate PTSD symptoms, such as pain, anxiety, disassociation and nightmares, for which hypnosis has been successfully used. It is also mentioned as a procedure that can be used for irritable bowel syndrome. Hypnosis should only be used by credentialed healthcare professionals who are properly trained in the clinical use of hypnosis and are working within the areas of the professional expertise? The total number of visits should be contained within the total number of psychotherapy visits. According to the ACOEM the goal of relaxation techniques is to teach the patient to voluntarily change his or her physiologic (autonomic and neuro-endocrine) and cognitive functions in response to stressors. Using these techniques can be preventative or helpful for patients in chronically stressful conditions, or they even may be curative for individuals with specific physiological responses to stress. Relaxation techniques include meditation, relaxation response, and progressive relaxation. These techniques are advantageous because they may modify the manifestations of daily, continuous stress. The main disadvantages are that formal training, at a cost, is usually necessary to master the technique, and the techniques may not be a suitable therapy for acute stress. Although the use of relaxation training and hypnotherapy is partially indicated by the above stated guidelines, the patient has been receiving an unknown quantity of sessions to date. Progress notes dating back to August 2014 were found.

The guidelines specifically state that the total number of sessions that are provided of this modality needs to be contained within the same number of cognitive behavioral treatment sessions. For most patients this would be a total of 13-20 sessions if progress is being made. In some cases, additional sessions up to a maximum of 50 can be provided in cases of severe psychiatric symptomology-major depression/PTSD which does not appear to be indicated in this particular situation. Although progress notes do reflect some patient progress as a result of her treatment, because the total number of sessions provided to the patient already is unclear and unspecified in the notes received for consideration is not possible to determine whether or not she is already received more than the maximum recommended by the treatment guidelines. As best as could be determined, the patient has been participating actively in cognitive behavioral therapy treatment and has recently been authorized for additional sessions. Although a treatment plan was provided, there was no update to determine whether or not progress is being made on the specific goals. No objectively measured instrumentation of improvement was provided (eg Beck Anxiety Inventory). Because of this, the medical necessity of the requested additional session was not established and therefore the utilization review determination for non-certification for this treatment modality is upheld.