MAXIMUS Federal Services

| Case Number: | CM15-0003220 | | |
|---|---|---|---|
| Date Assigned: | 01/14/2015 | Date of Injury: | 09/26/2012 |
| Decision Date: | 03/12/2015 | UR Denial Date: | 12/11/2014 |
| Priority: | Standard | Application Received: | 01/07/2015 |

## 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:

This 45 year old female was injured 9/26/12 injuring her left arm. Current symptoms include constant left shoulder pain with radiation up and down arm and sleep difficulties. Pain intensity was 9/10. Medications are Tylenol #3 and Anaprox. Treatments included steroid injection to left shoulder with temporary relief. Diagnoses include major depressive disorder, recurrent, severe without psychotic features; left shoulder impingement with sub acromial bursitis; status post left shoulder arthroscopic surgery with sub-acromial decompression 8/30/13 with marked residuals; anxiety and depression secondary to ongoing symptoms. Diagnostic studies included MRI and radiograph of the left shoulder. The treating provider requested cognitive behavior therapy, 6 sessions; her pain continues to bother her. On 12/11/14 Utilization Review non-certified the request for cognitive therapy sessions, 6 sessions frequency unspecified based on unclear number of sessions requested, the request was modified. MTUS, ACOEM and ODG were cited.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional Cognitive Behavioral Therapy, 6 sessions, frequency unspecified, per 12/3/14 Rx:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological intervention Page(s): 105-127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mental Illness and Stress Chapter

**Decision rationale:** It is unclear from the medical records as to how many psychotherapy sessions have been completed to date. Additionally, the improvements are noted to be "improved mood", which are not objective functional improvements. The ODG recommends an "initial trial of 6 visits over 6 weeks" and "with evidence of objective functional improvements, total of up to 13-20 visits (individual sessions)" may be necessary. As a result of insufficient information, the need for additional psychotherapy cannot be fully determined. As a result, th request for an additional 6 sessions is not medically necessary. It is ntoed that the injured worker did receive a modified authorization for 6 sessions (3 times over 2 weeks) in response to this request.