

<b>Case Number:</b>	CM15-0100374		
<b>Date Assigned:</b>	06/02/2015	<b>Date of Injury:</b>	05/05/2011
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	05/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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 is a 58 year old male with a May 5, 2011 date of injury. A progress note dated April 24, 2015, documents subjective findings (fair and deeper sleep on Belsomra; episodic illusions, seeing shadows, especially at night; episodic thoughts of being better off dead without any plan or intent to kill or hurt self; daily anxiety regarding medications not being authorized), objective findings (poor eye contact; constricted affect range; linear thought process, intermittently tangential; admits to rare auditory hallucinations; improved attention and concentration; fair judgment and insight), and current diagnoses (major depressive disorder, single episode, severe with psychotic features; adjustment disorder with anxiety; insomnia related to pain, anxiety, and depression; chronic pain). Treatments to date have included medications and individual therapy. The medical record identifies that the injured worker has been resistant to therapy and requires additional time to learn and implement techniques acquired in therapy. The treating physician documented a plan of care that included monthly medication management, weekly group cognitive behavioral therapy, weekly individual cognitive behavioral therapy, and a sleep study.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Medication Management Monthly x 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92. Decision based on Non-MTUS Citation ACOEM, Independent Medical Examinations and Consultations, Chapter 7, page 127 and Official Disability Guidelines, Pain Chapter, Online Version, Office visits.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398 B, Referral. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress chapter, topic Office Visits, Evaluation and Management (E&M). March 2015 update.

**Decision rationale:** Specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities some mental illnesses are chronic conditions, so establishing a good working relationship the patient may facilitate a referral for the return-to-work process. Treating specific psychiatric diagnoses are described in other practice guidelines and texts. It is recognized that primary care physicians and other non-psychological specialists commonly deal with and try to treat psychiatric conditions. It is also recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than 6 to 8 weeks. The practitioner should use his or her best professional judgment in determining the type of specialist. Issues regarding work stress and person-job fit may be handled effectively with talk therapy through a psychologist or other mental health professional. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy. The guidelines encourage and allow for outpatient visits to the offices of medical doctors for the proper diagnosis and returned a function of an injured worker. Although the MTUS is nonspecific for psychiatric evaluation, the ODG addresses it indirectly as Office Visits, Evaluation and Management (E&M) stating that they are a recommended to be determined as medically necessary. Evaluation and management outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and returned a function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care professional is individualized based on a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. A request was made for medication management monthly x 6 visits; the request was modified by utilization review to allow for 3 visits with the following provided rationale: "as per the April 24, 2015 report, the patient reports no change in the severity of anhedonia, poor concentration, attention and memory, mildly increased appetite, worthlessness and guilt feelings, low energy and fatigue, hopelessness and helplessness. He is prescribed multiple psychotropic medications including Seroquel, Wellbutrin XL, and trazodone... Follow-up medication management monthly is considered medically reasonable. However, quarterly evaluations of the patient's progress would be reasonable to evaluate for continued efficacy and progress of treatment." This IMR will address a request to overturn the utilization review determination of modified 3 visit certification and allow all 6 sessions. Although continued psychiatric treatment is indicated as medically reasonable and necessary for this patient at this juncture the request for 6 months worth of psychiatric treatment is excessive in quantity and duration without periodic intervals reestablishing the medical necessity of the request. Many psychiatric conditions can be sustained with psychotropic medications on a less than monthly schedule once stabilized. Because the request is excessive in terms of quantity the medical necessity is not established and therefore the utilization review determination is upheld.

## **Group CBT Weekly (Insomnia) x 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress chapter, topic: non-pharmacological treatment, cognitive therapy for insomnia. March 2015 update.

**Decision rationale:** The official disability guidelines recommend cognitive therapy for insomnia and note that "even brief cognitive behavioral therapy for insomnia can have good outcomes and reduce healthcare" utilization and costs. Up to 13 to 20 visits over a 7 to 20 week of individual sessions if progress is being made. "Decision: a request was made for Group Cognitive behavioral therapy Weekly (insomnia) x 6; the request was non-certified by utilization review with the following divided rationale: the guidelines provide recommendations for individual psychotherapy for insomnia treatment, but do not provide evidence to support group cognitive behavioral therapy for insomnia is medically necessary." There is no indication for cognitive behavioral therapy for insomnia as it is was noted that the patient is now sleeping 7 hours per night." This IMR will address a request to overturn this decision. Continued psychological treatment is contingent upon the establishment of the medical necessity of the request. This can be accomplished with the documentation of all of the following: patient psychological symptomology at a clinically significant level, total quantity of sessions requested combined with total quantity of prior treatment sessions received consistent with MTUS/ODG guidelines, and evidence of patient benefit from prior treatment session including objectively measured functional improvement. The documentation provided for supporting this request was insufficient to demonstrate and establish the medical necessity of the request. No treatment records from prior sessions of insomnia related to cognitive therapy treatment were provided. It is unclear whether or not the patient has received this treatment in the past and if so how many sessions were provided and what was the outcome. In addition the official disability guidelines recommend this treatment to be provided in individual sessions and do not support specifically the use of it in group treatment setting. Without further documentation regarding the patient's prior treatment with this modality and a rationale for why this request is being made at this juncture as the utilization review mentions that the patient is now sleeping 7 hours per week with new medication, the medical necessity of this request is not established and therefore the utilization review determination of not medically necessary and appropriate is upheld.

## **Individual CBT Weekly x 6 (Depression and Insomnia): Overturned**

**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, Cognitive Behavioral Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Part Two, Behavioral Interventions, Psychological Treatment; see also ODG Cognitive Behavioral Therapy Guidelines for Chronic Pain. Pages 101-102; 23-24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter Mental Illness and Stress, Topic: Cognitive Behavioral Therapy, Psychotherapy Guidelines March 2015 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 measurable/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 documented that CBT has been done and progress has been 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. Psychotherapy lasting for at least a year or 50 sessions is more effective than short-term psychotherapy for patients with complex mental disorders according to the meta-analysis of 23 trials. Decision: a request was made for individual cognitive behavioral therapy weekly x 6 (depression and insomnia) the request was non-certified by utilization review with the following provided rationale: "it is not clear from the available medical records how long the patient has been treated for his insomnia and how many visits of psychotherapy the patient has had, nor is there objective evidence of improvement was psychotherapy including returned to work and decreased reliance on medication... It is noted that the patient continues to attend individual therapy for depression and states it has been very helpful. However, despite subjective report that individual psychotherapy has been helpful, the patient reports no change in the severity of his symptoms, nor is it shown that there has been reduction in the patient's medication use a return to work..." This IMR will address a request to overturn the utilization review decision. Continued psychological treatment is contingent upon the establishment of the medical necessity of the request. This can be accomplished with the documentation of all of the following: patient psychological symptomology at a clinically significant level, total quantity of sessions requested combined with total quantity of prior treatment sessions received consistent with MTUS/ODG guidelines, and evidence of patient benefit from prior treatment session including objectively measured functional improvement. According to an individual psychotherapy progress note from May 8, 2015 the patient attended 27 prior treatment sessions. His participation was described as attentive and active and the treatment session focused on behavioral activation and modifying negative thoughts. It is noted that the patient continues to present with depressive symptoms but continues to appear more hopeful and optimistic about his future. He has continued to complete his hygiene 4 days of the week and took 36 minute walks on 5 different days, attended church one time a week and has been going to the marina with his wife to spend time with her. He also noted initiating a family gathering and has been changing negative thoughts and more useful thoughts as they relate to pain. As best as can be determined from the treatment progress notes that were provided the patient appears making progress in his treatment including objectively measured functional improvements and because he is diagnosed with severe major depressive disorder he would be eligible for additional treatment sessions than the standard 13 to 20 that are typically recommended according to the official disability guidelines. This is further supported by a notation by his primary treating physician April 10, 2015 the patient continues to have episodic thoughts of being better off

dead although no specific plan or intention. For this reason 6 additional individual psychotherapy sessions for depression and insomnia appear to be reasonable and medically appropriate and therefore the utilization review determination for non-certification is overturned.

### **Sleep Study x 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Online Version, Polysomnography (Sleep Study).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress, chapter topic: Polysomnography (PSG). March 2015 update.

**Decision rationale:** Polysomnography (PSG): Recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. Home portable monitor testing may be an option. A polysomnogram measures bodily functions during sleep, including brain waves, heart rate, nasal and oral breathing, sleep position, and levels of oxygen saturation. It is administered by a sleep specialist, a physician who is Board eligible or certified by the American Board of Sleep Medicine, or a pulmonologist or neurologist whose practice comprises at least 25% of sleep medicine. See the Pain Chapter for more information and references. In its Choosing Wisely list, the American Academy of Sleep Medicine (AASM) advises against polysomnography (PSG) in patients with chronic insomnia unless symptoms suggest a comorbid sleep disorder. Although PSG may confirm self-reported symptoms of chronic insomnia, it does not provide additional information necessary for diagnosis of chronic insomnia. However, PSG is indicated in some specific circumstances, for example when sleep apnea or sleep-related movement disorders are suspected, the initial diagnosis is uncertain, behavioral or pharmacologic treatment fails, or sudden arousals occur with violent or injurious behavior. In addition, do not use polysomnography to diagnose restless legs syndrome. (AASM, 2015) Criteria for Polysomnography: Polysomnograms / sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); (6) Sleep-related breathing disorder or periodic limb movement disorder is suspected; (7) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended; (8) Unattended (unsupervised) home sleep studies for adult patients are appropriate with a home sleep study device with a minimum of 4 recording channels (including oxygen saturation, respiratory movement, airflow, and EKG or heart rate). A request was made for sleep study x 1; the request was non-certified by utilization review with the following rationale: "the April 24, 2015 report does not indicate how long the patient has been treated for his insomnia or that the patient is unresponsive to behavioral intervention and sleep promoting medications as they continue to be recommended for this patient. The report also notes that the patient was previously authorized for sleep study but not completed within the authorized time line without

further clarification as to why this was the case. Moreover, in light of my peer to peer discussion with [REDACTED], there is no indication for CBT for insomnia as it was noted that the patient is now sleeping 7 hours per night." This IMR will address a request to overturn that decision. The Official Disability Guidelines with regards to sleep studies state that they are "not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders." The provided medical records do not document adequately the medical necessity of this request. There is no detailed discussion of the patient specific sleep related difficulties including documentation of symptoms of obstructive sleep apnea as specified in the above criteria. Because the medical records that were provided were insufficient to establish the medical necessity of this request the utilization review determination is not medically necessary.