

<b>Case Number:</b>	CM15-0106585		
<b>Date Assigned:</b>	06/10/2015	<b>Date of Injury:</b>	03/27/2014
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2015

### 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:

The injured worker is a 47-year-old male who sustained an industrial injury on 03/27/2014. Treatment provided to date has included: physical therapy, acupuncture (3), cognitive behavioral therapy (4), medications, and conservative therapies/care. Diagnostic tests performed include: CT scan (03/24/2014), MRIs of the cervical spine (09/07/2011 and 06/29/2014), and laboratory testing. There were no noted previous injuries or dates of injury, and no noted comorbidities. On 04/22/2015, physician progress report noted complaints of neck pain. Pain is rated as 6 (0-10) and described as constant, achy, burning, shooting, throbbing, tingling, radiating, numbing, pressure and deep. The pain was reported to be better with medications and sleep, and worst with activity and loud noises. Additional complaints include numbness, headaches, joint pain, muscle stiffness, depression, anxiety, stress and insomnia. Current treatments include medications (Relafen, Soma, Topamax, Buspar, Pamelor and Buspirone). The physical exam revealed decreased range of motion in the cervical spine. The provider noted diagnoses of concussion syndrome, cervical strain/sprain, and chronic pain syndrome. Plan of care includes continued acupuncture, physical therapy, suboccipital injections, continued neurology follow-up, electrodiagnostic testing, 4 sessions of cognitive behavioral therapy and neuropsychological testing. The injured worker's work status temporarily partially disabled. Requested treatments include 4 sessions of cognitive behavioral therapy and neuropsychological testing.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cognitive Behavioral Therapy times 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions. Decision based on Non-MTUS Citation ODG Cognitive Behavioral Therapy (CBT).

**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 ODG: Chapter Mental Illness and Stress, Topic: Cognitive Behavioral Therapy, Psychotherapy Guidelines March 2015 update.

**Decision rationale:** A request was made for cognitive behavioral therapy 4 sessions; the request was non-certified by utilization review with the following rationale: "there is documentation of 4 sessions of CBT completed to date. However, there is no documentation of objective functional improvement with previous psychotherapy." 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 including objectively measured functional improvements. According to the primary treating physician progress note May 21, 2015 the request for 4 sessions of cognitive behavioral therapy is made to "reinforce and develop pain coping skills." It is further noted that the purpose of the cognitive behavioral therapy is because "the patient has not responded adequately to physical medicine alone and has undergone cognitive behavioral therapy with the intent to stabilize the patient helping them to develop skills that will develop their ability to focus on reducing somatic complaints, decreasing symptoms of anxiety depression and increasing their repertoire pain management skills the additional cognitive behavioral therapy sessions will continue to focus on the following: stabilizing mood using cognitive strategies to challenge the patient's perceptions of helplessness and pain associated disability, promoting sleep hygiene and techniques for improving activity levels, teaching the patient to assume responsibility for their own recovery employing basic goal setting techniques to help them begin to construct a daily routine that is within the current limitations, and to help the patient develop skills that will allow them to focus on reducing somatic complaints, decreasing symptoms of anxiety and depression, and increasing the repertoire pain management skills." It is not clear when the patient began and psychological treatment however on medical records index notation there are medical records reported from July 21, 2014 and again in August 8, 2014 from psychologists. Additional dates of medical records from a treating psychologist are noted on September 9, 2014 as well as October 9, 2014. June 30, 2014 he was authorized for 4 sessions of cognitive behavioral therapy and it appears possible that this is approximately when his treatment began but this could not be determined definitively. He has been treated actively with several psychiatric psychotropic medications. In a treatment progress note from January 8, 2015 is noted that the patient reported having obtained 6 cognitive

behavioral therapy sessions through [REDACTED] office but that additional requests for this treatment modality were not authorized. Psychological treatment progress notes were not provided for this IMR but a summary of his psychological cognitive behavioral treatment is mentioned in a PQME report from March 30, 2015 that discusses severe depression and cognitive mood impairment that is worsening and treatment of severe depression that has arisen from his work-related injury with suicidal ideation without plan or intention. 6 additional sessions of cognitive behavioral therapy were requested on September 30, 2014. The medical necessity of the requested treatment is not established by the provided documentation. Although it does appear that the patient is continuing to suffer from psychological symptomology, the patient has received psychological treatment and could not be determined how many sessions the patient has received to date, as it is not clearly stated in the medical records. It is possible that for additional treatment sessions will not be excessive according to the MTUS guidelines however, the patient's prior psychological treatment was not adequately discussed in the medical records because there was no treatment progress notes provided a primary treating psychologist regarding his psychological treatment. There is no indication whatsoever of any patient benefit from prior psychological treatment. There is no mention from his primary treating physician about benefit received from psychological treatment received to date. Without further information regarding the patient's response to prior psychological treatment including the total quantity of sessions received, the medical necessity of this request was not established and therefore the utilization review determination for non-certification is not medically necessary.

**Neuropsychological testing:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 397.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines, Chapter Head, topic: Neuropsychological testing. March 2015 update.

**Decision rationale:** CA-MTUS is silent regarding the use of neuropsychological testing but the ODG states that it is recommended for severe traumatic brain injury, but not for concussions unless symptoms persist beyond 30 days. For concussion/ mild traumatic brain injury, comprehensive neuropsychological/cognitive testing is not recommended during the first 30 days post injury, but should symptoms persist beyond 30 days, testing would be appropriate. Neuropsychological testing should only be conducted with reliable and standardized tools by trained evaluators, under controlled conditions, and findings interpreted by trained clinicians. Moderate and severe TBI are often associated with objective evidence of brain injury on brain scan or neurological examination (e.g., neurological deficits) and objective deficits on neuropsychological testing, whereas these evaluations are frequently not definitive in persons with concussion/mTBI. There is inadequate/insufficient evidence to determine whether an association exists between mild TBI and neurocognitive deficits and long-term adverse social functioning, including unemployment, diminished social relationships, and decrease in the ability to live independently. Attention, memory, and executive functioning deficits after TBI can be improved using interventions emphasizing strategy training (i.e., training patients to compensate for residual deficits, rather than attempting to eliminate the underlying neurocognitive impairment) including use of assistive technology or memory aids. (Cifu,

2009) Neuropsychological testing is one of the cornerstones of concussion and traumatic brain injury evaluation and contributes significantly to both understanding of the injury and management of the individual. The application of neuropsychological (NP) testing in concussion has been shown to be of clinical value and contributes significant information in concussion evaluation, but NP assessment should not be the sole basis of management decisions. Formal NP testing is not required for all athletes, but when it is considered necessary, a trained neuropsychologist should perform it. Decision: a request was made for neuropsychological testing; the request is non-certified by utilization review with the following rationale provided: "there is documentation of chronic pain and depression/anxiety/stress. However, given documentation of a diagnosis of concussion syndrome: stable, there is no (clear) documentation of an indication (with supportive clinical findings) for which neuropsychological testing is supported (concussion when symptoms persist beyond 30 days)." This IMR will address a request to overturn the utilization review decision. According to the primary treating physician, progress note from May 21, 2015 the request for neuropsychological testing is "recommended by PQME [REDACTED] and [REDACTED]." According to the PQME report from May 6, 2015 it is noted that the patient should be referred to the acquired brain injury program through [REDACTED] and should be able to participate on an industrial basis in the program is provided free of charge. It is not clear whether this recommendation has occurred or not but it would be appropriate for this treatment to be completed prior to the consideration of additional psychological or neuropsychological testing. In addition, any treatment progress notes from this program could be submitted in support of this request, however none was found with paperwork included for this IMR. It was also recommended in the PQME that the patient undergo neuropsychological testing in order to determine the extent of a possible head injury and potential residual memory issues which may be labor disabling. However, that "this evaluator can find no evidence that this has occurred, but it should be pursued on an industrial basis in order to help determine what struggles Mr. [REDACTED] may face in attempting to return to the open labor market." The provided medical records do not support the use of neuropsychological testing at this juncture because although the patient does present with significant serious depression which appears to be causing persistent psychological symptomology (in contrast with neuropsychological symptoms but can often present that way), the medical documents provided do not clearly support neuropsychological evaluation in addition to the extensive and comprehensive psychological testing that he is recently received. For this reason the medical necessity of this request is not established in the utilization review determination for non-certification is not medically necessary.