

<b>Case Number:</b>	CM15-0168867		
<b>Date Assigned:</b>	09/09/2015	<b>Date of Injury:</b>	06/17/2013
<b>Decision Date:</b>	10/07/2015	<b>UR Denial Date:</b>	08/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 49 year old male, who sustained an industrial injury on June 17, 2013, resulting in pain or injury to the back. Currently, the injured worker reports increased pain and worsening sleep with a depressed mood with anhedonia, poor concentration and memory, poor self-esteem, feelings of uselessness, low energy, fatigue, hopelessness, helplessness, anxiety, and continuous chronic suicidal ideation, denying a plan or intent to kill or hurt himself. A review of the medical records indicates that the injured worker is undergoing treatment for major depressive disorder, single episode with psychotic features, insomnia related to depression, somatic symptoms disorder of predominately pain, chronic pain, lumbar myofascial pain syndrome, low back pain, degeneration of the lumbar disc, and physical injury disability. The Primary Treating Physician's report dated July 14, 2015, noted the injured worker reported he thought the Gabapentin was making his pain worse. The injured worker was noted to be despondent, with the Primary Treating Physician noting the psychiatric medications were not adequate. Per the Treating Physician's progress report dated July 18, 2015, noted the injured worker a less despondent and negativistic, with a depressed, anxious, and dysphoric mood. The Provider noted the injured worker's Primary Treating Physician was concerned about the injured worker expressing suicidal ideation and a report that the injured worker's Neurontin was making his pain worse, however the Provider noted the injured worker confirmed he wanted his Neurontin received from the Provider versus the Primary Treating Physician. The documentation provided also indicates the injured worker with worsened pain and sleep, tolerating his medications well. Prior treatments have included individualized psychotherapy, physical therapy, at least 18 sessions of cognitive behavioral psychotherapy, and current medications including Remeron, prescribed since at least March 4, 2015, Neurontin, prescribed since at least March 21,

2015, and Seroquel, prescribed on June 27, 2015. The request for authorization was noted to show that Remeron 15mg 2 tabs po at HS #60 with one refill, Seroquel 25mg one po at HS #30 with one refill, Neurontin 600mg 2 tabs po TID #180 with one refill, group psycho education for 6 sessions, and individual cognitive behavioral therapy (CBT) for 6 sessions were requested. The Utilization Review (UR) dated August 10, 2015, certified the requests for Remeron 15mg 2 tabs po at HS and Seroquel 25mg one po at HS #30 and 1 refill, modified the request for Neurontin to 600mg 2 tabs po TID #180 with no refill, modified the request for group psycho education to three sessions, and modified the request for individual cognitive behavioral therapy (CBT) to three sessions.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Neurontin 60mg, 2 tabs po tid #180 Refills 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** According to MTUS guidelines, "Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." There is no documentation that the patient sustained a neuropathic pain. In addition, according to the progress report dated July 14, 2015, the patient did report that Gabapentin is making his pain worse and does not want to take it. Based on the above, the prescription of Neurontin 60mg with 1 refill is not medically necessary

**Group psycho education - 6 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental illness & Stress Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cognitive therapy for depression <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, Cognitive therapy for depression is recommended "Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals." The patient underwent 19 CBT sessions without clear objective documentation for improvement. The patient continued to have pain and suicidal ideations. There is no clear evidence that 6 sessions of group psycho education will be helpful. The patient could be approved for 2 or 3 session and reevaluated for more session if efficacy. Therefore, the request for Group psycho education - 6 sessions is not medically necessary.

**Individual cognitive behavioral therapy (CBT) 6 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cognitive behavioral therapy (CBT). <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, cognitive therapy for specific guidelines, see Cognitive therapy for amputation; Cognitive therapy for depression; Cognitive therapy for opioid dependence; Cognitive therapy for panic disorder; Cognitive therapy for PTSD; Cognitive therapy for general stress; Cognitive behavioral stress management (CBSM) to reduce injury and illness; Dialectical behavior therapy; Exposure therapy (ET); Eye movement desensitization & reprocessing (EMDR); Hypnosis; Imagery rehearsal therapy (IRT); Insomnia treatment; Mind/body interventions (for stress relief); Psychodynamic psychotherapy; Psychological debriefing (for preventing post-traumatic stress disorder); Psychological evaluations; Psychological evaluations, IDDS & SCS (intrathecal drug delivery systems & spinal cord stimulators); Psychosocial /pharmacological treatments (for deliberate self harm); Psychosocial adjunctive methods (for PTSD); Psychotherapy for MDD (major depressive disorder); PTSD psychotherapy interventions; Stress management, behavioral/cognitive (interventions); Telephone CBT (cognitive behavioral therapy); Computer-assisted cognitive therapy. Studies show that a 4 to 6 session trial should be sufficient to provide evidence of 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. (Crits-Christoph, 2001) CBT, whether self-guided, provided via telephone or computer, or provided face to face, is better than no care in a primary care setting and is also better than treatment as usual, according to a meta-analysis. A subanalysis showed the strongest evidence for CBT in anxiety. For depression alone, CBT compared with no treatment had a medium effect size, computerized CBT had a medium effect, and guided self-help CBT for both depression and anxiety produced a small effect size. (Twomey, 2014) See Number of psychotherapy sessions for more information. ODG Psychotherapy Guidelines: Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.) In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made. There is no documentation of the goals and objectives of the proposed cognitive therapy. There is no documentation on how the patient will be monitored during the proposed therapy. Therefore, the request for Individual cognitive behavioral therapy (CBT) 6 sessions is not medically necessary.