

Case Number:	CM15-0169969		
Date Assigned:	09/10/2015	Date of Injury:	07/19/2004
Decision Date:	10/08/2015	UR Denial Date:	08/06/2015
Priority:	Standard	Application Received:	08/28/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 40 year old male, who sustained an industrial injury on 7-19-04. The injured worker was diagnosed as having mixed anxiety and depressed mood and posttraumatic stress disorder. Medical records dated 3-13-15, indicated 9 out of 10 pain and unable to return to work. He is able to drive and reported sleep improved with Trazodone (started in 2-2015). The physical exam on 6-5-15 revealed the injured worker has frequent night terrors, which awaken his 12-year son. The injured worker reported he has benefited from the treatment and feeling improved relaxation and better control over his hyperirritability. Treatment to date has included group psychotherapy (last session on 5-28-15), Tramadol, Norco and Xanax since at least 5-26-15. As of the PR2 dated 7-15-15, the injured worker reports problems with sleep. He rates his pain 6 out of 10 and spends most of his time on the couch or in bed. The treating physician noted that the injured worker goes to group meetings three times a week, but has not gone recently due to pain. The treating physician requested cognitive behavioral therapy x 12 sessions and Xanax 1 mg #60. On 7-28-15 the treating physician requested a Utilization Review for cognitive behavioral therapy x 12 sessions, Prazosin 1 mg #120, Xanax 1mg #60 and Prozac 10mg #60. The Utilization Review dated 8-6-15, non-certified the request for cognitive behavioral therapy x 12 sessions and Xanax 1 mg #60 and certified the request for Prazosin 1mg #120 and Prozac 10mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve (12) cognitive behavioral sessions: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cognitive Behavioral Therapy (CBT) Guidelines for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment.

Decision rationale: The California chronic pain medical treatment guidelines section on psychological treatment states: 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 function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and post-traumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. See also ODG Cognitive Behavioral Therapy (CBT) Guidelines. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005) Psychological treatment in particular cognitive behavioral therapy has been found to be particularly effective in the treatment of chronic pain. As this patient has continued ongoing pain, this service is indicated per the California MTUS and thus is medically necessary.

One (1) prescription of Xanax 1mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Alprazolam.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: The California chronic pain medical treatment guidelines section on benzodiazepines states: Benzodiazepines Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005) The chronic long-term use of this class of medication is recommended in very few conditions per the California MTUS. There is no evidence however of all failure of first line agent for the treatment of anxiety or Insomnia in the provided documentation. For this reason the request is not medically necessary.