

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0186695 |                              |            |
| <b>Date Assigned:</b> | 09/28/2015   | <b>Date of Injury:</b>       | 07/19/2012 |
| <b>Decision Date:</b> | 11/13/2015   | <b>UR Denial Date:</b>       | 09/01/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/22/2015 |

### 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, Texas

Certification(s)/Specialty: Psychiatry, Geriatric Psychiatry, Addiction Psychiatry

### 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 53 year old male whose date of injury is 07/19/2012, involving a motor vehicle accident with injuries to the right hand, shoulder, and left knee. He was treated with epidural steroid injection in 2013, spinal surgery in 2013 and 2014, and carpal tunnel release in 2015. Diagnoses included major depressive disorder and PTSD. On 03/25/2015, a psychiatric AME indicated that he was not yet permanent and stationary and required indefinite psychiatric care. He began psychotherapy with [REDACTED] on 08/12/2014. Progress notes by [REDACTED] of 06/24/2015 indicate that the patient's condition had plateaued and no further improvement was expected. Medications included citalopram 40mg, Ativan 0.5mg prn, and Prazosin. There are pain management notes of 07/15/2015 and orthopedic progress notes of 07/16/2015. The patient complained of pain radiating to the right lower extremity, left hand, right hip, and mid back. It was increased on the right side of the body with spasms, and he experienced balance issues with limited range of motion. Pain was rated at 8/10. He had a history of having failed Norco and Tramadol provided limited relief. He was prescribed Percocet, gabapentin, cyclobenzaprine, and lidoderm patch. On 07/22/2015, [REDACTED] reported stress, decreased energy and concentration, difficulties with emotional control and stress tolerance. As his condition could not be cured, he continued to require services to prevent deterioration and to provide symptom relief to allow minimum function at home and in the community. On 09/01/2015, UR modified the request for 4 individual/group CBT to #4 and Ativan 0.5mg to #45.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Individual/group CBT (cognitive behavioral therapy), QTY: 12.00:** 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 CA-MTUS is silent regarding individual/group CBT for major depressive disorder and PTSD, Official Disability Guidelines, Mental Illness & Stress, Cognitive therapy for depression, Cognitive therapy for PTSD.

**Decision rationale:** ODG recommends cognitive therapy for depression and PTSD, up to 50 sessions for patients who are suffering for severe cases. [REDACTED] documented that the patient continues to show emotional dysregulation, therefore continued psychological services are medically necessary. UR of 09/01/2015 partially certified a request for 12 individual/group CBT to #4. No records were provided to show that these sessions were provided and it appear that they are still outstanding. This request is therefore not medically necessary until further progress notes are provided.

**Activan 0.5mg, QTY: 60.00:** 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): Benzodiazepines.

**Decision rationale:** Benzodiazepines are not recommended for long-term use over four weeks due to the potential for dependence, abuse, and side effects. They are not the treatment of choice in anxiety disorders. There is no demonstrated efficacy in records provided and no rationale for continued use. This request is not medically necessary.