

<b>Case Number:</b>	CM15-0187164		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	05/05/2011
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	08/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2015

### 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 58 year old male, who sustained an industrial injury on 05-05-2011. He has reported subsequent back, hip and knee pain, depression and anxiety and was diagnosed with thoracic and lumbar sprain, lumbar disc herniation, chronic right knee pain status post right knee replacement, major depressive disorder, severe with psychotic features, adjustment disorder with anxiety and insomnia related to pain. Treatment to date has included pain medication, anti-depressants, anti-psychotic medication, individual psychotherapy and group psychotherapy. The injured worker was noted to have had 38 cognitive behavioral psychotherapy sessions as of 08-14-2015. In an individual psychotherapy progress note dated 08-14-2015, the injured worker's mood was noted to be less depressed but high levels of anxiety were noted. The injured worker was noted to continue to complete hygiene, daily exercising, to attend church once a week and had been spending quality time with his family. The injured worker was noted to continue to have a myriad of negative thoughts about himself and his capabilities which resulted in high anxiety. Deep breathing techniques and progressive muscle relaxation techniques were worked on during session. In a progress note dated 08-21-2015, the injured worker reported slightly less duration of sleep (6.5-7 hours) on a taper off Trazodone and that he did not decrease dose of Trazodone due to fear of losing sleep. The injured worker reported slight decrease in severity of depression, anhedonia, better energy level, slightly improved concentration and less hopelessness, mildly increased appetite, worthlessness and guilt feelings and helplessness which was noted to be unchanged. The injured worker reported episodic illusions, seeing shadows, especially at night and episodic thoughts of being better off

dead without any plan or intent to kill or hurt self. The injured worker also reported daily anxiety that fluctuated in intensity and marked sexual dysfunction. Mental status examination showed poor eye contact, constricted range of affect, blunted affect, intermittently tangential thought process, improved attention and concentration and fair judgment and insight. The treatment plan included continuing individual therapy for depression and insomnia and continued medications. A request for authorization of medication management, 6 sessions and individual CBT (cognitive behavioral therapy), 6 sessions was submitted. As per the 08-31-2015 utilization review, the request for medication management sessions was non-certified and the request for cognitive behavioral therapy was modified to certification of 4 sessions of cognitive behavioral therapy.

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

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

#### **Medication management, 6 sessions: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) medical reevaluations.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested service. The ODG, states follow up medical visits are based on medical necessity and the patient's progress, symptoms and ongoing complaints. In this case, the request is for 6 follow up visits/medication management. The continued ongoing need for these medications cannot be determined for that many sessions. Therefore the request is not medically necessary.

#### **Individual CBT (cognitive behavioral therapy), 6 sessions: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines: Mental Illness & Stress - Psychotherapy guidelines; 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 posttraumatic 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.