

<b>Case Number:</b>	CM15-0209459		
<b>Date Assigned:</b>	10/28/2015	<b>Date of Injury:</b>	07/17/2007
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	10/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2015

### 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: California

Certification(s)/Specialty: Internal 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 42 year old female, who sustained an industrial injury on 7-17-2007. Diagnoses include major depressive disorder, anxiety disorder, and chronic pain. Treatments to date include psychotherapy and medications. The records indicated treatment for complaints of pain in the neck and bilateral hands, and also anxiety attacks and depression. Evaluated on 9-25-15, she reported feeling less sleeping, getting about 9 hours nightly but not feeling rested in the morning. It was noted she was "constantly late to individual psychotherapy" due to "forgetting". The physical examination documented a constricted affect with blunted quality. Attention-concentration was noted as improved and memory noted as "forgetful". The provider documented a request to authorize a sleep study based on "a markedly elevated Epworth scale (actual test and result documented on 8-21-15 to have a result of 21 corresponding to Class III impairment due to insomnia) and increased weight gain secondary to decreased activity due to injury." An individual psychotherapy progress note dated 10-2-15, documented that was visit number 5. The record indicated she reported daytime sleepiness effecting concentration and a history of missing appointment as a result. She was documented observed to yawn and "dozing off" during the session. The mood was depressed and affect constricted. Treatment included discussion on tools to utilize to assist with remembering appointments and importance of compliance. The appeal requested authorization for a polysomnographic sleep study and six (6) cognitive therapy sessions, once a week for six weeks. The Utilization Reviews dated 10-6-15, denied the requests.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Polysomnography sleep study: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Polysomnography.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Up to date topic 7695 and version 34.o.

**Decision rationale:** Obstructive sleep apnea is diagnosed by polysomnography and is secondary to increased frequency of obstructive apneic events and hypopneas due to repetitive collapse or narrowing of the upper airways during sleep and results in daytime symptoms such as sleepiness and fatigue. Other symptoms which are often manifested are waking up holding one's breath, gasping, or choking. Often snoring and breathing interruptions are noted by one's partner during sleep. Sequela of sleep apnea is the development of HBP, mood disorders, CAD, CVA, CHF, A fib, and DM. The CPAP machine is the mainstay treatment for this condition. The patient has symptoms of daytime somnolence and poor memory in spite of sleeping 9 hours. She also feels she has not rested. These could be symptoms of sleep apnea which could have severe negative consequences for a patient. Therefore, the physician needs to rule out sleep apnea and this test is indicted. The UR decision is overturned. The request is medically necessary.

### **Cognitive therapy once a week for 6 weeks: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Behavioral interventions. Decision based on Non-MTUS Citation Official Disability Guidelines, Cognitive Behavioral Therapy (CBT) guidelines for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Stress-Related Conditions 2004, Section(s): Work-Relatedness, and Chronic Pain Medical Treatment 2009, Section(s): Psychological evaluations, IDDS & SCS (intrathecal drug delivery systems & spinal cord stimulators), Psychological treatment.

**Decision rationale:** The chronic pain section states that in chronic pain it is often beneficial to have psychological intervention. This would include setting goals, understanding the patients pain beliefs and cognitive functioning. The AECOM relates that cognitive behavior psychotherapy may be beneficial in stress reduction and that the idea is to change ones perception of pain, stress, and subjective approach to his disabilities and problems. This type of therapy has been found to be effective in short-term control of pain and also in treating the long term effects of pain and in facilitating return to work. The AECOM states that the initial patient assessment is critical for detecting emotional problems requiring referral to a psychiatrist Red flag symptoms indicating an urgent referral to a psychiatrist or other mental health provider include impaired mental functioning, overwhelming symptoms, or signs of substance abuse. The AECOM also states that psychological referral is often indicated if significant psychopathology or serious comorbidities are present. It also states that severe stress related

depression and schizophrenia should be referred to a specialist. However, common conditions such as mild depression can be handled by the PCP. However, if the depression lasts for more than 6 to 8 weeks a psychiatric referral may be considered. Lastly, issues related to work stress or person- job fit may be handled with talk therapy with a Psychologist or other mental health professional. More serious conditions should be sent to a Psychiatrist for consideration of treatment with medication. The patient's depression has been present for about 8 years and it is worthwhile to have a psychiatrist involved in this case of chronic and refractory depression associated with chronic pain. Also, the patient should be afforded cognitive therapy in order to seek to change her perceptions of her pain and disability and to seek to give her coping mechanisms. Therefore, the UR decision is reversed. This request is medically necessary.