

<b>Case Number:</b>	CM15-0048095		
<b>Date Assigned:</b>	03/20/2015	<b>Date of Injury:</b>	08/25/2000
<b>Decision Date:</b>	04/24/2015	<b>UR Denial Date:</b>	03/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2015

### 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 51-year-old female whose date of injury is 8/25/2000. She was diagnosed with transmandibular joint disorders NOS; spondylosis NOS; salivary secretion disturbance; disc degeneration NOS; depression with anxiety; chronic pain syndrome; post laminectomy lumbar syndrome; disc disorders of the lumbar spine; sciatica; low back pain. Treatment to date has included status post lumbar laminectomy; psychological evaluation (2/25/15); TENS unit; trigger point injections (8/20/14, 12/9/14); MRI thoracic and lumbar spine - significant for thoracolumbar scoliotic rotary curvature (10/13/14); medications. She currently complains of upper, left sided mid to low back pain, bilateral lower extremity pain, left hip and bilateral feet pain, and bilateral wrist and hand complaints. A pre-surgical psychological evaluation of 02/25/15 for a possible multilevel spinal fusion for the management of chronic pain issues, revealed Beck Inventories in the severe range for anxiety and depression, PHQ9 severe for depression. It was felt that she was showing a moderate to severe reactive depressive/anxiety disorder. She related that she suffered from chronic depression for 10-12 years, which had worsened for the last 2 years due to deterioration of spinal integrity, along with daily panic attacks. Diagnosis given on a request for authorization is major depressive disorder single episode. She was on sertraline for depression. Other medications include Methadone, Norco, diazepam, Flector, Levoxyl, ibuprofen, omeprazole, and Simvastatin. She has a past treatment history of 15 psychotherapy visits with a local psychologist which were reported as helpful around two years ago. UR of 03/06/15, noncertified this request. In the peer to peer with the

provider at that time, the rationale given was it was felt that "her mood would respond...affecting her pain perception." No further documentation was provided.

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

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

**Cognitive behavioral therapy (8 sessions): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. See also Multi-disciplinary pain programs.ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone:- Initial trial of 3-4 psychotherapy visits over 2 weeks- With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions) Page(s): 23 of 127.

**Decision rationale:** The patient shows evidence of depression/anxiety shown on the Beck Inventories and PHQ9 scales. There is a history reported of prior psychotherapy, which was helpful around two years ago but it is unclear what gains were made. No clear rationale was provided for the request for CBT. In addition, MTUS recommends an initial trial of 3-4 sessions followed by assessment for objective functional improvement. The request for 8 CBT sessions falls outside of these recommendations. This request is therefore noncertified.