MAXIMUS Federal Services

Case Number:	CM14-0126568		
Date Assigned:	08/13/2014	Date of Injury:	12/10/2012
Decision Date:	10/27/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/11/2014

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. The expert reviewer is licensed in Psychology and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records that were provided for this independent review, this 60-year-old male patient reported an industrial/occupational injury that occurred on December 10, 2012. On the date of his injury the patient was working as a butter room machine operator for [redacted]. where he worked for 37 years often 12 hour days, 6 to 7 days per week. He was struck in the head by a stainless steel lid and started to experience severe headache and neck pain. This resulted in head injury, chronic pain, and psychological symptomology. He presents with neck pain, severe headache, and depression. He described the pain as aching and dull, intermittent, deep and sharp like a knife in the head, and dull over his eye and ear areas. He has been diagnosed with the following psychological disorders: Adjustment Disorder, Unspecified; Rule out Personality Change Due To a Closed Head Injury; Rule out Cognitive Disorder. Upon examination he was seen to have Post-Concussive Syndrome, Depression, and Insomnia. He has been treated by a psychiatrist on a monthly basis psychiatric medication follow-up as well as ongoing assessment. He reports that he had a psychological evaluation and just a few psychotherapy visits and biofeedback sessions with a psychologist he did not continue because he switched medical doctors and was unsure if he should continue his psychological treatment under a new primary treating physician. He was not certain whether the treatments were helping him or not. He had a psychological evaluation in October 2013 and again in April 2014. A neuropsychological evaluation was also completed in June 2013. Currently, he is anxious without panic attack he finds himself worrying often about his financial situation and his medical condition, he tends to have anger episodes and periods of frustration and his activities of daily living are severely restricted. He was diagnosed with: Depression, Not Otherwise Specified, Moderate Severity; Anxiety Not Otherwise Specified, Moderate; Cognitive Disorder Not Otherwise Specified per History; and Chronic Pain Disorder Associated with Both Psychological

Factors and Orthopedic Condition. This psychological evaluation contained a summary of the prior neuropsychological evaluation was completed in June 2013 and concluded that the patient had mild cognitive problems and that these may have been resulting from "the pain, fatigue from insomnia, emotional reactions, and medications." And that the neuropsychological testing at that time did not show post-concussive residuals. The testing revealed diminished attention and concentration and ability to retain an organized verbal material. CT of the head was negative and MRI of the brain found "only chronic micro-ischemic vascular disease, presumably in the white matter due to metabolic syndrome." The report recommended 15 sessions of therapy and biofeedback with psychologist and d/c very heavy coffee (15 cups+); also it stated that if there is a cervicogenic component due to unconscious paracervical muscle tension that EMG biofeedback should be able to address it. The results of the April 2014 psychological assessment confirmed below average attention/concentration and reasoning and that sensitivity to room noise resulted in increased headache and difficulty concentrating and reasoning. Continued complaints of constant headache and neck pain worsening throughout the day and pain in his left year pressure over his left eye in the back of his head were noted. He continues to report irritability, depression, emotional, easily frustrated, anger, social withdrawal and tends to be sleeping during the day and staying awake at night. A request was made for cognitive behavioral therapy twice a month for duration of three months. The requested treatment would be under the care of a different psychologist than the one he saw in 2013. The request was not approved; the rationale was stated: "that a peer review should be done to clarify the question of chronic pain source in order to make an appropriate determination as to what type of treatment would benefit the injured worker. If the patient has cognitive problems consideration of neuropsychological testing would be indicated again to determine what type if any treatment would be warranted."

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive Behavioral Psychotherapy Two Times A Month For Three Months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines Cognitive Behavioral Therapy (CBT)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part Two, Behavioral Interventions, Cognitive Behavioral Therapy Page(s): 23 -24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, Topic Cognitive Behavioral Therapy Psychotherapy Guidelines, June 2014 Update.

Decision rationale: According to the MTUS guidelines behavioral interventions are recommended, the identification and reinforcement of coping skills is often more useful in the treatment of pain that ongoing medication or therapy could lead to psychological or physical dependence. An initial trial of 3 to 4 psychotherapy visits over a two-week period should be offered and with evidence of objective functional improvement, a total of up to 6-10 visits over a 5-6 week period of individual sessions offered. The official disability guidelines states that after initial trial patients who are making progress in their therapy may have up to 13-20 sessions authorized; and in cases of severe psychopathology such as PTSD and Severe Major Depression, additional sessions up to a maximum of 50 may be offered if progress is being made. Progress is typically defined as objective functional improvement which is measured by: an increase in activities of daily living, a reduction on future medical treatment, and reduction in work

restrictions, if applicable. With respect to this patient, he does meet the criteria of medical necessity for psychological treatment based on his psychological symptomology. However, the patient had a prior course of psychological treatment in 2013 and the results of those sessions do not reflect objective functional improvements. It appears that he is also had, possibly, several sessions recently with a new treating psychologist. Although, there were no medical records provided from this treatment. If he did have treatment sessions in 2014 the continuation of the treatment is contingent on medical records being provided that reflect what occurred in those sessions and the outcome meeting the criteria of objective functional improvement. This was not provided. If in fact this is a request to start a course of psychological treatment, the treatment protocol states that 3-4 psychotherapy visits over a two-week period should be offered and if there is improvement, an additional total up to 6 to 10 visits can be offered over 5 to 6 weeks. This request is covering a span of 12 weeks which is nearly double what would be recommended. The medical necessity of additional sessions, or an initial treatment as requested, cannot be established.