

Case Number:	CM14-0128418		
Date Assigned:	09/05/2014	Date of Injury:	06/06/2012
Decision Date:	09/30/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	08/12/2014

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 Board Certified in Psychiatry & Neurology, Addiction Medicine, has a subspecialty in Geriatric Psychiatry 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:

Records reviewed include 429 pages of medical and administrative records. The injured worker is a 52 year old male whose date of injury is 06/06/2012. He lifted one side of a piano; it fell three feet backward into a wall causing twisting of his spine. He received physical therapy, aquatic therapy, injections, and surgery. He has bilateral compressive wrist neuropathies. Orthopedic diagnoses are cervical spinal cord stenosis, disorders of bursae and tendons in the shoulder region unspecified, carpal tunnel syndrome, and chronic pain syndrome. His psychological evaluation of 12/12/2013 show that he has been coping poorly emotionally since his injury, feeling sadness due to his inability to provide for his family. His diagnoses were major depressive disorder, and anxiety disorder due to chronic pain syndrome. His Beck Inventories were clinically significant for anxiety=41, depression=47. Since that time his Beck Inventories have ranged from anxiety of 34-52 and depression of 43-59. The most recent PR2 is dated 04/10/14 and indicates that he was using his CBT tools better and more often to manage sleep interruptions. He continued to show improvement in his marriage and socialization, whereas previously his wife had been considering divorce. Beck Inventories were anxiety=43, depression=48 and he had fewer suicidal thoughts. He was showing objective functional improvement and up to that date per records provided it appears that he has received around 9 sessions of CBT. In a primary treating physician's progress report of 09/02/14 the patient's chief complaint was his neck pain, then left arm radiating pain, and right anterior shoulder pain. He had discontinued opioid medications. He was taking Topamax, Lipitor, Omeprazole, Lorazepam for anxiety, and a nonnarcotic pain medication (unknown).

IMR ISSUES, DECISIONS AND RATIONALES

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

Four (4) CBT (Cognitive Behavioral Therapy) follow-ups: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Cognitive Therapy for Depression.

Decision rationale: CA-MTUS: 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. 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).ODG: Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). (Paykel, 2006) (Bockting, 2006) (DeRubeis, 1999) (Goldapple, 2004) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. (Gloaguen, 1998) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. (Corey-Lisle, 2004) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. (Pampallona, 2004) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. (Royal Australian, 2003) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. Maintenance cognitive-behavioral therapy (CBT) to prevent recurrent depression is most effective in patients at highest risk for relapse, defined as those with 5 or more previous depressive episodes. For individuals at more moderate risk for recurrence (fewer than 5 prior episodes), structured patient psychoeducation may be equally effective. High-risk patients in particular may benefit from specific elements of maintenance CBT by reducing cognitive vulnerability factors for recurrent depression, such as ruminating, negative attributions and memories, and dysfunctional beliefs, or by maintaining positive emotions when experiencing stress. (Stangier, 2013)ODG Psychotherapy Guidelines:Initial trial of 6 visits over 6 weeksWith evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks

(individual sessions)The patient has shown objective functional improvement manifested by his Beck Inventory scores for anxiety and depression decreasing from the 50's range, and the improvements in his marriage and social isolation. The patient has become an active member in his church in areas such as teaching. He related that he utilizes his CBT tools. He should be afforded the opportunity to solidify the gains made to allow him to cope with his pain (without opioid medications) and sleep disturbance. ODG psychotherapy guidelines are up to 20 sessions. Unless records are provided to the contrary, this patient has used around nine. As such this request of four (4) CBT (Cognitive Behavioral Therapy) follow-ups is medically necessary and appropriate.