

Case Number:	CM14-0162133		
Date Assigned:	10/07/2014	Date of Injury:	06/27/2007
Decision Date:	10/31/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	10/02/2014

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 medical records, this patient is a 64-year-old male who reported an industrial accident that occurred on June 27, 2007. The injury occurred during his normal regular work duties as a cement truck driver when the cement chute on his truck was improperly positioned by another driver prompting it to fall on his hand and crushed it he was transported immediately to the hospital and released the following day. When he returned a few days later for a procedure there was a revision amputation done of the distal thumb tip and he stated he was surprised and upset by the amputation and did not recall signing the informed consent for it to be done. It had been his understanding that the surgical procedure was merely a placement of a skin flap over the thumb tip and communication may have been a problem because he speaks Spanish as his primary language but is fluent in English and there may have been a language problem. The injury was a traumatic right thumb crush injury with residual moderate to severe neuropathic pain and cervical pain. The injury has resulted in three surgeries including partial amputation and disarticulation of the right thumb. He reports continuing current burning constant pain to the right some area which radiates up his arm and into the shoulder and sometimes cervical region. His current psychiatric medications include Celexa and Ambien. A comprehensive psychiatric examination in September 2010 reflects prior medications included Zoloft and Topamax. He did participate in psychiatric treatment in 2009/2010 and eventually these medications were discontinued the current ones. He was diagnosed at that time with depressive disorder not otherwise specified, and it was recommended that he participate in a course of psychological treatment for 16 to 20 sessions. The results of that prior course of treatment were not discussed anywhere else in his medical chart that was provided, and there is no mention of whether or not it occurred. An initial psychological note from September 2013 and included psychological testing that revealed mild depression and anxiety and he was diagnosed with: Pain disorder

associated with both psychological and physical factors. The initial treatment plan was for brief cognitive behavioral therapy four sessions with biofeedback to reduce pain and increased general coping. At that time he mentioned that he has had conventional medical treatment with some benefit from medications and acupuncture (unhelpful) and that the pain impacts his life very much because he can no longer play music as he used to and that he used to be a professional mariachi musician and that his sex life is also affected with pain and sensitivity to touch in his thumb area and that he is not been able to returned to work full-time. There is good benefit reported from the medication Celexa. Psychological progress report in February 2014 reflects notes related to cognitive behavioral therapy and biofeedback and time per month on average and he reports improved sleep with good mood and full affect. Psychological progress report PR-2 dated April 2014 states that the patient has increased stress but he has been able to practice relaxation learned in prior sessions, including diaphragmatic breathing, and autogenic training he reports a pain level of 5/10 and was introduced to heart rate variability training in his treatment session he was able to obtain medium and high periods very briefly is average at the end of practice was 72% low, 15% medium, and 13% high coherence. This was described as his first session this type of biofeedback. His mood and affect were described as normal according to a PR-2 progress report from August 2014. A request was made for four visits of cognitive behavioral therapy, the request was not certified. The utilization review rationale for non-certification was stated as: "there is no psychological evaluation report in the file, there is one biofeedback progress report... And no data about the scope, components of, or benefits from psychological input thus far and no information about why psychotherapy is necessary at this time".

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive Behavioral Therapy x 4 visits: Upheld

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

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

Decision rationale: According to the MTUS treatment guidelines, psychological treatment is 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 functioning, and addressing comorbid mood disorders such as depression, anxiety, panic disorder, and PTSD. The identification and reinforcement of coping skills is often more useful in the treatment of chronic pain and ongoing medication or therapy which could lead to psychological or physical dependence. An initial treatment trial is recommended consisting of 3-4 sessions (up to 6 sessions ODG) to determine if the patient responds with evidence of measureable/objective functional improvements. Guidance for additional sessions is a total of up to 6-10 visits over a 5 to 6 week period of individual sessions. The official disability guidelines

allow somewhat more of an extended treatment and recommend 13-20 sessions maximum for most patients who are making progress in their treatment; in some unusually complex and severe cases of Major Depression (severe intensity) and/or PTSD up to 50 sessions if progress is being made. With respect to this patient, it appears that additional documents were provided for this independent medical review that may not have been available at the time of the original utilization review decision. There were several progress notes that were provided and not just one as indicated and was comprehensive psychological evaluation as well. Progress notes that were provided did contain sufficient detail that reflected patient progress in treatment and it appears that the treatments are being beneficial to him. However, there was no total number of sessions provided and documentation that was provided was insufficient to calculate an estimation of how many had occurred. There was some indication that he is attending treatment at a level, i.e. less than once a week, in which case it is entirely possible that request for four additional sessions might fall within guidelines. Because the treatment guidelines specify at the more generous ODG recommendations 13-20 but it was not possible to determine whether or not he is within that range. He does not qualify based on the degree of psychiatric and psychological symptomology for the extended sessions above 50 as his level of psychiatric symptomology is in the mild to moderate range. In addition, there appears to be a prior course of psychological treatment that was recommended, because no documentation was provided with regards to this treatment is unclear whether or not it actually occurred, and if it did whether or not there was objective functional improvement and how many sessions were offered. This information is needed because it would help to determine whether or not he is eligible for additional treatment at this time.