MAXIMUS Federal Services

Case Number:	CM14-0168160		
Date Assigned:	10/15/2014	Date of Injury:	10/26/2006
Decision Date:	11/18/2014	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	10/13/2014

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 that were provided for this IMR this patient is a 52 year old male who reported an industrial/occupational injury that occurred on October 26, 2006. The injury occurred during his full-time employment as a service technician at [redacted]; he was walking to retrieve a car that two tires were stored at a height of 25 feet and weighing approximately 25 to 35 pounds came down upon him and hit him over his head and shoulders causing him to lose consciousness. He was revived while in transport to the hospital but blacked out again and subsequently treated on an emergency basis. Medically, a partial list of the patient's diagnoses include: Cervical Spondylosis; Post Laminectomy Syndrome Lumbar Region; Osteoarthritis Unspecified Shoulder; Unspecified Internal Derangement Knee. He reports frequent/constant headaches, neck pain that radiates to the bilateral upper extremities, low back pain which radiates to the bilateral lower extremities with numbness and shoulder pain which radiates to the upper extremities and bilateral ankle/feet pain. He also reports memory deficit, sexual dysfunction, urinary incontinence/urgency/frequency, dental pain, sleep disorder, and erectile dysfunction. He has also been diagnosed with: "end-stage post-concussive injury that followed a mild traumatic brain injury with complete loss of capacity to care for himself requiring 24/7 home health care assistance with previously failed lumbar spine fusion procedures, knee arthroscopic procedures, left shoulder procedures as well as multiple pain management procedures none of them providing him with substantial relief." Psychologically, he reports severe anxiety, depression, and insomnia. He reports severe limitations in his activities of daily living with dependency on his wife and daughter to assist with bathing, dressing, putting on socks and shoes, meal preparation and driving; he cannot walk for very long and uses a cane or walker. He avoids socializing and has associated severe depression, anxiety, confusion, memory loss and symptoms of major depression and anxiety. He was hospitalized in 2012 for severe

depression with suicidal ideation and hallucinations. His psychological diagnoses include Severe Major Depressive Disorder with Psychotic Features, and Phobic Disorder. A comprehensive psychological evaluation from November 2013 provided a slightly alternative diagnosis as follows: Depressive Disorder, Not Otherwise Specified, Anxiety Disorder Not Otherwise Specified, Pain Disorder Associated with Both Psychological Factors and a General Medical Condition. His medications for psychiatric treatment include Risperdal and Zoloft, Cymbalta and Topamax. He has required crisis intervention and inpatient treatment psychotherapy and was hospitalized again in June 2014 with suicidal intent to overdose on his medications. He was discharged approximately two weeks later after stabilizing. Hospitalization was reported to be helpful in conjunction with the daily inpatient therapy. At the time of discharge it was recommended he continue psychotherapy five times a week to provide him with coping skills, relaxation training, systematic desensitization therapy, and cognitive behavioral therapy, to help him to control his feelings of frustration and desperation especially when his suicidal ideations become activated. His prior psychological treatments have included individual therapy, group therapy, psychotropic medicine and psychiatric hospitalization. A request was made for individual psychotherapy 12 times per month for three months for a total of 36 sessions. Utilization review rationale for non-certification was stated that the patient has had prior visits of psychotherapy but that the number of visits and specific outcomes and functional increases resulting from prior treatment is not specifically identified within the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Individual psychotherapy 12 times per month times 3months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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 treatment guidelines, psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. An initial treatment trial is recommend 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's psychological treatment, there are several issues when considering a request for additional sessions. First, the treatment medically necessary is based on patient symptomology and patient progress in treatment as defined as objective functional improvements; defined as increased activities of daily living, reduced work restrictions (if applicable), and a reduction in dependency

on future medical care. With respect to continued patient symptomology, he does meet the criteria of significant, ongoing, chronic, and severe psychopathology. However, with respect to objective functional improvements, there was insufficient evidence of this that meets the above stated definition. His symptomology and psychological status appear to be relatively stable in its chronicity with fluctuations occurring during times of psychiatric flare-up, but without substantial changes in activities of daily living, or dependency on future medical need. The issue of returning to work is not applicable in this case. The 3rd issue is of session quantity; the total number of sessions that he has had to date was not clearly stated. Over 3300 pages of treatment progress notes were provided, it does appear that his psychological treatment has been going on for many years and at least since 2011 under the care of the provider. His psychological treatment history prior to 2011 is unclear, but given that he has had over three years of treatment that is documented, it appears likely that he is exceeded the 50 session maximum for severely complicated cases. The request for 36 to be completed in a three-month period greatly exceeds treatment guidelines and protocols which specify the need for ongoing assessment of medical necessity. Because the request for 36 more sessions does not meet the threshold of medical necessity the UR decision for non-certification is upheld.