

Case Number:	CM14-0184920		
Date Assigned:	11/12/2014	Date of Injury:	03/20/2007
Decision Date:	12/31/2014	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/06/2014

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 as they were provided for this IMR, this patient is a 31-year-old female who reported a work-related injury that occurred on March 20, 2007 during the course of her employment for [REDACTED]. The mechanism of injury was not provided for this review. Medically, she has been treated for a lesion of the ulnar nerve, arm joint pain, carpal tunnel syndrome, forearm joint pain, and unspecified mononeuritis. This review will focus on the patient's psychological symptomology as it pertains to the requested treatment. She has been diagnosed with the following psychological disorder: Severe Reactive Depression. A note from her primary treating physician on May 19, 2014, states that the patient "would benefit from cognitive behavioral therapy to learn non-pharmacological management of chronic pain and coping strategies. A 9 item "patient health questionnaire" PHQ-9 showed a score of 19/30 indicating moderate to severe depression. A trial of the antidepressant medication Cymbalta was recommended by her primary treating physician, however the patient declined. A similar primary treating physician note from August 11 2014 states patient should continue in her cognitive behavioral therapy program and that her PHQ-9 score was 27/30 indicating severe depression. A request for 8 sessions of cognitive behavioral therapy was made in October 2014 with a notation that the patient is "finding the treatment quite helpful." It is unclear whether or not she received her participated in those 8 sessions. The current request was made for additional cognitive behavioral therapy 6 sessions for her right elbow, the request was non-certified; this IMR will address a request to overturn that decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional cognitive behavioral therapy times 6 for the right elbow: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions; Psychological treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cognitive Behavioral Therapy (CBT)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions, Cognitive behavioral therapy Page(s): 23-24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental illness and stress chapter, Cognitive behavioral therapy, Psychotherapy guidelines.

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 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 (ODG) allow a more extended treatment. According to the ODG studies show that a 4 to 6 sessions trial should be sufficient to provide symptom improvement but functioning and quality-of-life indices do not change as markedly within a short duration of psychotherapy as do symptom-based outcome measures. ODG psychotherapy guidelines: up to 13-20 visits over a 7-20 weeks (individual sessions) if progress is being made. The provider should evaluate symptom improvement during the process so that treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate. In some cases of Severe Major Depression or PTSD up to 50 sessions, if progress is being made. The medical records that were provided for this review were insufficient to support the medical necessity the requested treatment. Medical records contained no specific psychological treatment progress notes regarding her prior psychological treatments. No communications from her primary treating psychologist were found in the records provided. No comprehensive initial/intake psychological/psychiatric evaluation was provided. No detailed information with respect to how many treatment sessions and over what duration of time has already been provided. No quantitative information was provided to support the contention of patient improvement from prior treatment. A brief depression screening tool administered by her primary treating physician Dr.'s office indicated an increase in depressive symptomology over a period of time spending from May 2014 to August 2014. There were no specific treatment goals or plans provided with regards to this or prior sessions with expected dates of accomplishment, or prior dates of goals accomplished by treatment. There was no information regarding the nature of her psychiatric/psychological symptoms as they relate to the injury. The mechanism of her injury was not provided nor was there a discussion of how it resulted in psychological symptomology. The guidelines suggest that a course of treatment of 13-20 sessions maximum for most other patients is sufficient, but in this case it was not clear how many sessions she has

already received and for how long she's been in treatment. No information was provided with regards to the nature and content of the psychological treatment she is receiving in terms of treatment modalities and specific interventions. Continued psychological care is contingent upon not only substantial patient psychological symptomology but also evidence of objective functional improvements from prior treatment. Due to insufficient documentation of the patient's prior course of psychological treatment and objective functional improvements derived from it, the requested treatment's medical necessity was not established.