

<b>Case Number:</b>	CM15-0125641		
<b>Date Assigned:</b>	07/10/2015	<b>Date of Injury:</b>	01/02/2008
<b>Decision Date:</b>	08/07/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/29/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Psychologist

### CLINICAL CASE SUMMARY

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

The injured worker (IW) is a 46 year old female who sustained an industrial injury on 01/02/2008. She reported an injury to the left foot. The injured worker was diagnosed as having reflex sympathetic dystrophy, Equino/Varus left lower limb foot and ankle and depression secondary to physical pain and functional loss. Treatment to date has included medications, an Arizona AFO (ankle foot orthotics) brace, x-rays, exercises for the ankle, treatment with a neurologist, and psychiatric counseling. Currently, the injured worker complains of pain primarily around the distal course of the posterior tibial tendon, and the peroneal tendons unilaterally on the left side. The left foot has significant guarding to motion, and inversion and aversion to resistance on the left side. There is no evidence of acute swelling or erythema, and there is allodynia to light touch on the left foot. Medications include clindamycin phosphate topical 1% gel, cyclobenzaprine, Cymbalta, duloxetine, enteric coted Naprosyn delayed release, Gabapentin, Naproxen, Omeprazole, Soma, Tramadol, Tylenol #3, Zolpidem. A request for authorization is made for the following: Cognitive Behavioral Psychotherapy, Qty 6.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cognitive Behavioral Psychotherapy, Qty 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Part Two, Behavioral Interventions, Psychological Treatment; see also ODG Cognitive Behavioral Therapy Guidelines for Chronic Pain. Pages 101-102; 23-24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter Mental Illness and Stress, Topic: Cognitive Behavioral Therapy, Psychotherapy Guidelines March 2015 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 to determine if the patient responds with evidence of measurable/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 documented that CBT has been done and progress has been 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. Psychotherapy lasting for at least a year or 50 sessions is more effective than short-term psychotherapy for patients with complex mental disorders according to the meta-analysis of 23 trials. A request was made for cognitive behavioral psychotherapy 6 sessions, the request was non-certified by utilization review with the following provided rationale: "worker with 7.5 history of physical injury with associated emotional distress who is been provided a prior two- year course of psychotherapy with unknown benefit. In as much as (the patient) has already been afforded psychological input that exceeds the industrial maximum for scope of treatment and the proposed additional input has the goal of relapse prevention is not endorsed by the industrial guidelines, additional psychological intervention on an industrial basis as per the industrial guidelines is not clinically supported..." This IMR will address a request to overturn that decision and approve 6 cognitive behavioral therapy sessions. According to a PR-2 from the patient's primary treating psychologist on June 4, 2015, the patient was treated with psychotherapy for depression starting on March 15, 2011 through November 21, 2013. It is noted that the therapist saw the patient again on August 14, 2014 without authorization or payment for the purpose of requesting authorization for treatment for her as she decompensated severely and had psychotic symptoms and depression without ongoing therapy. The patient noted: "without therapy, I got so bad that I went to the ER at the hospital and they sent me to [REDACTED] in 72 hour hold. Now and getting medication I can think straight again but I need more help than just medicine." By the requesting psychologist that "it is crucial that she not lapse back into a psychotic condition." And that behavioral psychotherapy is recommended by the patient's PCP to develop new techniques for developing skills for coping with pain, harassment, and depression. According to the provided medical records, the patient remains psychiatrically and psychologically symptomatic at a clinically significant level that appears to necessitate medical treatment. However, the request for additional treatment does not meet the standard of medical necessity because she has already

been provided an extensive course of psychological treatment of unknown duration and session quantity but spanning a course of 2 years at the minimum. The official disability guidelines suggest a typical course of psychological treatment should consist of 13 to 20 sessions. There is an exception that can be made in cases of very extreme and severe major depressive disorder PTSD that would allow additional treatment sessions up to 50 sessions or one year of treatment. The additional sessions are contingent upon the establishment of medical necessity which requires documentation of patient benefit which includes objectively measured functional improvement (for example activities of daily living decreased dependency on future medical, reduced work restrictions if applicable, increased physical activity and socialization etc.). In this case, the exception appears to apply based on the patient's recent psychiatric hospitalization. However, based on the provided medical records it appears that the patient has already well exceeded the maximum treatment quantity for the exception as well. No comprehensive treatment plan with stated goals and estimated dates of accomplishment or detailed intake psychological evaluation were included in the documents provided for consideration for this IMR. Because of this, there was no establishment of patient benefit from prior psychological treatment (which is not to say that it did occur only that it was not provided). The medical necessity of this request is not established per industrial related guidelines. Because the medical necessity the request was not established, the utilization review determination for non-certification is upheld. The request is not medically necessary.