Case Number:	CM15-0127530		
Date Assigned:	07/14/2015	**Date of Injury:**	03/24/2006
Decision Date:	08/11/2015	**UR Denial Date:**	06/30/2015
Priority:	Standard	**Application Received:**	07/01/2015

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 53 year old male who sustained an industrial injury on 03/24/2006. The mechanism of injury and initial report of injury are not found in the records reviewed. The injured worker was diagnosed as having thoracic or lumbosacral neuritis or radiculitis, unspecified; degeneration of lumbar or lumbosacral intervertebral disc; acquired spondylolisthesis; brachial neuritis or radiculitis not otherwise specified. Treatment to date has included diagnostic testing, exercise, and injections of the low back. In the visit of 01/06/2015, the worker is seen in follow up of bilateral knee pain. His additional diagnoses are internal derangement, right knee; ACL tear, left knee; osteoarthritis knee, left, severe; and knee pain. He has increased symptomology in the right knee that he feels is attributable to over compensation with the left knee which is scheduled for a total knee arthroplasty in March of 2015. Pain is reported at 3-4 on a scale of 10. The injured worker also complains of back pain and joint pain. He denies joint swelling, muscle cramps, muscle weakness, numbness, stiffness, arthritis, ankle swelling, tingling sensation, or difficulty walking. Medications include Trazodone, and Nucynta. On exam, there is full range of motion bilaterally in the joints of the lower extremities; there is normal tone and strength to testing of the knee flexors and extensors, ankle dorsiflexors and plantar flexors. On the right knee, tenderness is noted over the fibular head and distal IT band. There is no crepitis in the right knee. The MRI demonstrated no evidence of ligamentous or meniscal pathology and a trial cortisone injection was recommended. Due to complaint of lateral knee and thigh pain, a home exercise program of stretching was given, and a physical therapy prescription was given.In a visit of 12/22/2014 to the spine specialist, the worker presented for

re-evaluation of knee, low back and neck pain, complaining that his neck pain has been more significant. The pain radiates to the bilateral arms with numbness and tingling. There was an earlier electromyogram of upper and lower extremities that showed a left C6 radiculopathy as well as left carpal tunnel syndrome and a right S1 radiculopathy. The worker would like to consider injection of the neck as well as surgery on the hand depending on what a new electromyogram and nerve conduction shows. He states his pain levels are a 5 out of 10 without medication, decreasing to a 3 on a scale of 10 with medication. He has aching low back pain radiating to the posterior legs, also worse on the left and bilateral knee. He feels instability in his left knee. In regard to the back, a MRI of the lumbar spine on 11/27/2013 demonstrated L5-S1 neural canal congenitally deformed but no spinal stenosis. There were hypertrophic facet changes bilaterally, and there is a 3-4 mm disc protrusion which extends into both neural foramens exit zones. At L4-5 there is a broad based disc protrusion with an annular tear, and at L3-4 there are posterior ligament and facet hypertrophic changes and a 2-3mm disc protrusion. Lt L2-3 there is posterior ligament and facet hypertrophy changes. Exam of the cervical spine found tenderness in the paracervical muscles of the mid and lower cervical spine, worse on the left. Lumbosacral spine examination showed tenderness in the paraspinal muscles and decreased range of motion in all fields. An opioid risk tool on 04/16/2014 and 06/25/2014 gave a score of 13 indicating high risk. Urine toxicology screens from 08/29/14, 009/15/2014 and 11/21/2014 were consistent with medications prescribed. A CURES report from 12/15/2014 was consistent with having a single prescriber of narcotic medication. The plan of treatment in the 12/22/2014 visit was for an updated electromyogram of the bilateral upper extremities. to assess for nerve root dysfunction versus an upper extremity entrapment. Further plans would be made for pain relief after the study results were reviewed. A request for authorization is made for the following: Cognitive Behavioral Therapy, 6 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive Behavioral Therapy, 6 sessions: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive Behavioral Therapy, psychological treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part Two, Behavioral Interventions, and 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: Citation Summary: 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. Decision: A request is made for cognitive behavioral therapy 6 sessions; the request was non-certified by utilization review with the following provided rationale: "in this case, although the patient notes he is getting depressed, provided documentation does not identify specific goals for treatment as it appears a psychological evaluation has not yet been performed. Without a psychological evaluation to determine whether cognitive behavioral therapy is appropriate and outline specific treatment goals such therapy the request for cognitive behavioral therapy x6 cannot be supported as medically necessary and therefore is recommended for non-certification." This IMR will address a request to overturn the utilization review decision for non- certification. According to a January 7, 2015 evaluation by the patient's primary treating physician the patient is diagnosed with (along with his physical injury related diagnoses) Depression. The patient has undergone a considerable amount conventional therapy and is experiencing delayed recovery. The patient completed a PHQ-9 questionnaire and scored 10 which is indicative of moderate depression is noted that "he is not suicidal he is depressed secondary to his pain." The utilization review rationale for non-certification of this request is that the patient has not received a comprehensive psychological evaluation yet. According to the MTUS guidelines for psychological evaluations they are well-established diagnostic and assessment instruments but not every patient needs to have one. In this case the medical records that have been submitted or sufficient to demonstrate that the patient is experiencing psychological symptomology at a clinically significant level that a referral to a psychologist would be appropriate and medically necessary and therefore the utilization review decision is overturned. Continued psychological treatment is contingent upon the establishment of the medical necessity of the request. This can be accomplished with the documentation of all of the following: patient psychological symptomology at a clinically significant level, total quantity of sessions requested combined with total quantity of prior treatment sessions received consistent with MTUS/ODG guidelines, and evidence of patient benefit from prior treatment including objectively measured functional improvements. The request is medically necessary.