MAXIMUS Federal Services

Case Number:	CM15-0171560		
Date Assigned:	09/11/2015	Date of Injury:	10/06/2011
Decision Date:	10/14/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	08/31/2015

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 is a 39 year old male who sustained an industrial injury on 10-06-2011. Current diagnoses include major depression-single episode, and anxiety disorder. Report dated 07-17-2015 noted that the injured worker presented for psychological follow up. The physician noted that the injured worker states that his pain level has remained the same. Pain level was 8 out of 10 on the visual analog scale (VAS) in the arms, hands, neck, back, and legs. Depressive symptoms include feelings of sadness, a loss of pleasure in participating in usual activities, social avoidance, sleep disturbance, appetite changes, and denied suicidal ideation. Anxiety based symptoms include health worries, social apprehension-especially in crowds, panic attacks, and symptoms of physical trembling, and heart palpitations. Cognitive issues include inability to concentrate, mind tires easily, and short term memory lapses. Interpersonal issues include feeling irritable around others, avoiding friends and family, and yelling more or cursing at others. Objective findings include depressed mood, affect is restricted, goal directed thought process, alert, good attention, orientation in all spheres, recent memory is fair, and remote memory is good. Beck Depression Inventory score was 54. Beck Anxiety inventory score was 31. Previous treatments included medications, cognitive behavioral therapy, and psychotherapy. The treatment plan included requests for additional cognitive behavioral therapy sessions because the patient continues to struggle with chronic pain and co-morbid mood disorders, and biofeedback therapy. The injured worker is on temporary partial disability until 10-17-2015. Report dated 08-05-2015 notes that the injured worker has completed 5 sessions of cognitive behavioral therapy.

The utilization review dated 08-13-2015, non-certified the request for biofeedback therapy and cognitive behavioral therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofeedback therapy #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Behavioral interventions, Biofeedback.

Decision rationale: According to the MTUS treatment guidelines for biofeedback it is not recommended as a stand-alone treatment but is recommended as an option within a cognitive behavioral therapy program to facilitate exercise therapy and returned to activity. A biofeedback referral in conjunction with cognitive behavioral therapy after four weeks can be considered. An initial trial of 3 to 4 psychotherapy visits over two weeks is recommended at first and if there is evidence of objective functional improvement a total of up to 6 to 10 visits over a 5 to 6 week period of individual sessions may be offered. After completion of the initial trial of treatment and if medically necessary the additional sessions up to 10 maximum, the patient may continue biofeedback exercises at home, independently. A request was made for biofeedback therapy 10 sessions, the request was non-certified by utilization review which provided the following rationale for its decision: "given non-certification of an associated request for cognitive behavioral therapy total 10 there is no documentation of biofeedback not as a stand-01 treatment. In addition, the proposed biofeedback therapy total 10 exceeds the recommended four visits (for an initial total furthermore there is no documentation of a discussion or rationale as to why such may not be applicable." This IMR will address a request to overturn the utilization review decision. The medical necessity of the requested treatment is not supported by the provided documentation. According to a treatment progress note from April 11, 2015 the patient remains psychologically symptomatic at a clinically significant level. However despite a lengthy treatment report that included psychometric testing, there was no discussion provided whatsoever regarding the quantity of treatment that has already been provided to the patient. Treatment progress notes indicate a number of sessions but it does not appear to be a cumulative total but rather a relative total to the authorization. Because the quantity of sessions and what the patient has received was not clearly stated, it could not be determined whether additional sessions are consistent with the industrial guidelines. The MTUS guidelines for Biofeedback indicate a maximum of 6-10 sessions, after completion the patient should be able to utilize the techniques independently at home. The patient has already received some biofeedback treatment sessions although the quantity was not reported, this request for 10 sessions in conjunction with the already received biofeedback treatments would exceed the recommended MTUS guidelines for this treatment modality. In addition to likely exceeding session treatment quantity recommended on an industrial basis by the industrial guidelines, the medical records that were provided do not contain or reflect significant and substantial functional improvement as a direct result of psychological treatment. They do provide in great detail the patient's psychological

symptoms as shown on an assessment instrument (Beck Inventories), but there's no discussion of objectively measured functional goals having been met and when they were met, nor is there a comprehensive treatment plan with estimated dates of accomplishment of specific goals. For these reasons the medical necessity the requested procedure is not established and utilization review decision is upheld.

Cognitive Behavioral Therapy #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Behavioral interventions, Psychological treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter Mental Illness and Stress, Topic: Cognitive Behavioral Therapy, Psychotherapy Guidelines, August 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 recommend up to 13-20 visits over 7-20 weeks (individual sessions) and 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 10 sessions of cognitive behavioral therapy; the request was non- certified by utilization review which provided the following rationale for its decision: "within the associated medical file there is documentation of previous CBT. However, there is no documentation of objective functional improvement with previous treatment. In addition, there is no documentation of the number of previous psychotherapy visits to determine if the recommended 10 visits have already been exceeded or will be exceeded with the additional request. Furthermore there is no documentation of a discussion or rationale as to why such may not be applicable." This IMR will address a request to overturn the utilization review decision. 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 medical necessity of the requested treatment is not supported by the provided documentation. According to a treatment progress note from April 11, 2015 the patient remains psychologically symptomatic at a clinically significant level. However despite a lengthy treatment report that included psychometric testing, there was no discussion provided whatsoever regarding the quantity of treatment that has already been provided to the patient. Treatment progress notes do number of sessions but it does not appear to be a cumulative total but rather a relative total to the authorization. Because the quantity of sessions the patient has received was not clearly stated, it could not be determined whether additional sessions are consistent with the industrial guidelines. The utilization review mentions the MTUS guidelines for psychological treatment indicating a maximum of 10 sessions. However in this case the official disability guidelines would probably be more applicable which would allow 13 to 20 sessions maximum for most patients with an exception being made in some cases of severe major depression contingent upon evidence of objectively measured functional improvement. The medical records that were provided do not contain or reflect significant and substantial functional improvement as a direct result of psychological treatment. They do provide great detail regarding the patient's symptoms but there's no discussion of objectively measured functional goals that have been met and when they were met, nor is there a comprehensive treatment plan with estimated dates of accomplishment of specific goals. For these reasons the medical necessity of the requested procedure is not established and utilization review decision is upheld.