

Case Number:	CM15-0021152		
Date Assigned:	02/10/2015	Date of Injury:	06/08/2009
Decision Date:	07/21/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	02/03/2015

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 34 year old male, who sustained an industrial injury on June 8, 2009. The mechanism of injury was a slip and fall from a big top, twenty five feet to the asphalt. The injured worker has been treated for head, left arm and rib complaints. The injured worker sustained a head injury, broken left arm and three fractured ribs. The injured worker was noted to be in a coma for seven days. Diagnoses have included pain disorder, cognitive disorder and depressive disorder. Treatment to date has included medications, psychological assessments, cognitive behavior psychotherapy, physical therapy and chiropractic treatments. Current documentation dated November 26, 2014 notes that the injured worker reported neck, back, right shoulder and upper extremity pain. The injured worker also noted nervousness, depression, constant headaches and leg numbness with prolonged standing. The pain was rated an eight out of ten on the visual analogue scale. Examination showed the injured worker to be logical and coherent. No symptoms suggestive of a psychotic disorder were perceived. The treating physician's plan of care included a request for individual psychotherapy sessions # 8 and a psychoneurologist referral.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Individual Psychotherapy Sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment 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 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 was made for the individual psychotherapy sessions, the request was non-certified by utilization review with the following provided rationale: "the request for individual psychotherapy sessions is medically necessary. The patient has been diagnosed with depression and anxiety since his industrial injury, which is in accordance with the cited guideline and recommendation for an initial trial of psychotherapy sessions. The provider stated that the patient had participated into, one-hour individual psychotherapy sessions on November 4, 2014 and November 25, 2014. Based on the guideline recommendations of 6 visits for an initial trial, and the patient already completing to sessions, the request for 8 individual psychotherapy sessions is recommended certified modification to 4 individual psychotherapy sessions with the remaining 4 individual psychotherapy sessions non-certified." 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.

According to a psychological evaluation from November 26, 2014 the patient was injured when he fell approximately 25 feet from a circus tent and injured his head, face, upper extremities and ribs. He is noted to have significant depression and has been diagnosed with the following: Depressive Disorder Not Otherwise Specified, Anxiety Disorder Not Otherwise Specified, Cognitive Disorder Not Otherwise Specified in Pain Disorder Associated with Both Psychological Factors and a General Medical Condition. Psychological treatment does appear medically appropriate and indicated for this patient based on the psychological evaluation that was provided for consideration. He appears to meet the criteria as a "properly identified patient per MTUS guidelines." However, for session quantity being requested is not consistent with the treatment protocol recommended in both the MTUS and the official disability guidelines or a brief initial treatment trial. The MTUS guidelines specify that an initial brief treatment trial should be provided consisting of 3 to 4 sessions whereas the official disability guidelines recommend a brief treatment trial consisting of 4 to 6 sessions. In this case the request for 8 sessions exceeds both of these guidelines. Additional sessions upon completion of the initial brief treatment trial may be offered contingent upon the establishment of medical necessity including evidence of patient benefited from prior treatment sessions including objectively measured functional indices of change and patient progress in treatment. Because this request is not follow the initial treatment trial protocol the medical necessity the request is not established on this basis solely. This is not to say the patient does not require psychological treatment only that the quantity requested does not conform to current guidelines. For this reason the medical necessity the request is not established and therefore the utilization review determination modification is upheld.

Psychoneurologist: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines, chapter: head, neuropsychological testing, March 2015 update.

Decision rationale: Citation summary: The neither the MTUS guidelines or the official disability guidelines address the request for a psychoneurologist, however the official disability guidelines do address the request for neuropsychological testing/evaluation. Official disability guidelines, Chapter Head, topic: Neuropsychological testing. March 2015 update. Citation Summary Recommended for severe traumatic brain injury, but not for concussions unless symptoms persist beyond 30 days. For concussion/mild traumatic brain injury, comprehensive neuropsychological/cognitive testing is not recommended during the first 30 days post injury, but should symptoms persist beyond 30 days, testing would be appropriate. Neuropsychological testing should only be conducted with reliable and standardized tools by trained evaluators, under controlled conditions, and findings interpreted by trained clinicians. Moderate and severe TBI are often associated with objective evidence of brain injury on brain scan or neurological examination (e.g., neurological deficits) and objective deficits on neuropsychological testing, whereas these evaluations are frequently not definitive in persons with concussion/mTBI. There is inadequate/insufficient evidence to determine whether an association exists between mild TBI

and neurocognitive deficits and long-term adverse social functioning, including unemployment, diminished social relationships, and decrease in the ability to live independently. Attention, memory, and executive functioning deficits after TBI can be improved using interventions emphasizing strategy training (i.e., training patients to compensate for residual deficits, rather than attempting to eliminate the underlying neurocognitive impairment) including use of assistive technology or memory aids. (Cifu, 2009) Neuropsychological testing is one of the cornerstones of concussion and traumatic brain injury evaluation and contributes significantly to both understanding of the injury and management of the individual. The application of neuropsychological (NP) testing in concussion has been shown to be of clinical value and contributes significant information in concussion evaluation, but NP assessment should not be the sole basis of management decisions. Formal NP testing is not required for all athletes, but when it is considered necessary, it should be performed by a trained neuropsychologist. A request was made for a referral to a psychoneurologist, the request was non-certified by utilization review of the following provided rationale: "the patient was previously certified in review #383996 on 7/31/13 for a referral for a neurological evaluation based on continued issues with the patient's brain which caused him anxiety, dizziness, and at one point a seizure. The reasoning the provider is requesting a referral for a psychoneurologist was based on the fact that he is unsure if this was previously done. Seeing that the patient was previously certified for this request, the request for another referral to a psycho neurologist is not necessary." This IMR will address a request to overturn the utilization review decision. This request might be appropriate for this patient at this juncture, however the medical necessity of this request could not be established due to insufficient documentation. However, the patient sustained an injury on June 8, 2009 In the totality of medical records provided for this IMR consisted of only 9 to 10 pages of clinical information with the total medical records provided at 28 pages with the vast majority of it being utilization review communications. There is a notation in a 9 page psychological evaluation that states the following: in terms of his cognitive status, the patient is alert and well oriented his remote and short-term memory seems adequate for the purpose of this evaluation, but his immediate memory- is impaired digit span is 4 (digits).His thinking is logical, coherent, goal-directed and significant for his industrial injury. Although this evaluation does suggest the patient has an impaired short-term memory, this is the only information provided to warrant this request for neuropsychological evaluation. There is no clear statement of the reason for this request. There is insufficient supporting documentation with respect to the patient's prior neuropsychological treatments if any. Without further substantiation of the medical necessity of the request for this intervention the medical necessity the request is not established. The patient has been authorized for psychological treatment, upon completion of this treatment and with further documentation, this request could be revisited. At this juncture without significant documentation establishing the necessity and purpose of the request, as well as history of prior neuropsychological and neurology evaluations (it appears that he has had at least one prior neurological evaluation in 2013 which is needed) to determine whether or not more an extensive "Psychoneurologist" is necessary. The request itself should be further clarified in terms of what is precisely being requested as well as the rationale and specific symptoms to be addressed. For this reason the medical necessity of this request is not established in the utilization review determination of non-certification is upheld.

