

Case Number:	CM15-0023204		
Date Assigned:	02/12/2015	Date of Injury:	01/22/2009
Decision Date:	04/03/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/06/2015

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:

According to the provided medical records, this 48 year old female patient reported a work-related injury that occurred on January 22, 2009 during the course of her employment for THX Ltd. The injury reportedly occurred during her employment as an administrative assistant when she lifted a large package of papers in the copy room and felt a sharp pain in her back, left shoulder, and knee. She was originally treated with physical therapy ice and rest with medical leave. Ultimately she received a two-part surgery in July and August 2013 including a laminectomy and fusion. Surgical complications resulted in new back damage resulting in her having difficulty walking and was necessitated assisted ambulation and a 3 week hospitalization resulting diminished physical condition, psychological symptoms of depression and anxiety and the need for another surgery to undo the prior one. This IMR will focus on her psychological treatment and symptoms. According to a treating Psychiatry progress notes PR-2 from January 16, 2015 her current psychiatric medications include Effexor and Remeron but discontinued Trazadone as it was not beneficial, the patient denies any side effects from either of the medications. She reports feeling anxious about an upcoming back surgery to "repair the results of the previous one" and the following symptoms: poor energy levels and concentration loss of libido, forgetfulness feelings of guilt and worthlessness, irritability, anger, insomnia most nights and increased appetite. She has been diagnosed with the following psychological diagnoses: Major Depressive Disorder, single episode, moderate; Insomnia related to Major Depressive Disorder. She reports that she is continuing in group cognitive behavioral pain therapy and states that it is beneficial but she finds that she gets depressed from the condition of other group

members and she reported that she completed a group for insomnia and states that she learned some useful techniques to improve sleep. According to a progress note from September 2014 the patient reports less depression as a result of group therapy. There is a notation from an October 13, 2014 psychological exam that she began psychological treatment group therapy sometime around early 2014. The specific date was not provided nor was the total number of sessions that she has received. Group psychotherapy progress notes were provided and were numbered however the numbering system was unclear, for example a note from 11/24/14 indicates session number 2 of CBT and one from 12/1/14 says number 3 of CBT for insomnia but another note from a few weeks later says session number 11 of CBT on 12/15/14. And it appears that treatment started in early 2014. Another note from 9/13/14 is labeled as session number 1 and states "review of previous material." A request for three psychological treatment modalities was made 6 sessions of each of the following: group cognitive behavioral therapy, hypnotherapy, and monthly medication management. All 3 were non-certified. This IMR will address a request to overturn these decisions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Group cognitive behavioral therapy; 6 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 19-23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Stress and Mental Illness Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2, behavioral interventions, cognitive behavioral therapy for chronic pain; see also part 2, behavioral interventions, psychological treatment Page(s): 23-24; 101-102. Decision based on Non-MTUS Citation Official disability guidelines, mental illness and stress chapter, 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 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. Decision: All the provided medical records were carefully considered for this review. Authorization of continued psychological treatment is continued on establishing medical necessity for the request, all 3 of the following factors must be documented and significantly evidenced: continued patient psychological symptomology that requires treatment, patient benefit from prior treatment sessions including objectively measured functional improvement, and that the total quantity of sessions requested falls within the above stated guidelines for quantity. The patient does continue to report some anxiety and depression and insomnia with noted improvements in her levels of depression and insomnia based on prior treatment and medications and somewhat worsening levels of anxiety pending an upcoming reversal surgery. The progress notes were provided reflect only minimal discussion of patient benefit from treatment but there were some indications throughout the progress notes that the patient is benefiting and making progress. No comprehensive treatment plan was provided based on prior sessions indicating stated goals with expected and anticipated dates of completion nor was there any indication of what treatment goals have already been reached. Although these first 2 issues were adequately addressed, the total quantity of sessions at the patient has received was unclear. MTUS/official disability guidelines specify that for most patients course of psychological treatment consisting of 13-20 sessions maximum in total is recommended. It was not possible to determine how many sessions this patient is already received and whether or not the request for 6 additional sessions would exceed this guideline. There is an exception that can be made in cases of severe psychological symptomology but this would not apply in this case. The total number of sessions at the patient has received to date could not be estimated accurately because there was an indication and she started psychological treatment in early 2014 however a conflicting piece of information on the progress notes labels session numbers in a manner that could not be sorted out with any clarity. It is important that session numbers are totaled cumulatively rather than relative to the authorization which appears possible in this case. If the patient has only had 12 sessions than an additional 6 sessions would be medically appropriate, however she actually began treatment in early 2014 and has already received more than 13-20 sessions that it would not be. Either way this issue could not be conclusively established. Therefore the medical necessity is not established. Because medical necessity is not established the request to overturn the utilization review determination is not approved.

Hypnotherapy; 6 sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Stress and Mental Illness Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines, mental illness and stress chapter, topic: hypnosis. March 2015 update.

Decision rationale: The CA-MTUS guidelines are nonspecific for hypnosis, however the official disability guidelines does discuss the use of hypnosis and says that it is recommended as an option, a therapeutic intervention that may be an effective adjunct to procedure in the

treatment of post-traumatic stress disorder PTSD. And hypnosis may be used to alleviate PTSD symptoms, such as pain, anxiety, disassociation and nightmares, for which hypnosis has been successfully used. It is also mentioned as a procedure that can be used for irritable bowel syndrome. Hypnosis should only be used by credentialed healthcare professionals who are properly trained in the clinical use of hypnosis and are working within the areas of the professional expertise. The total number of visits should be contained within the total number of psychotherapy visits. Decision: No specific rationale stated for the reason and rationale why hypnotherapy would be needed in this particular case. There is some indication of anxiety but this would not warrant the use of hypnotherapy which is typically reserved for cases of PTSD. The patient does not have a diagnosis of PTSD. The medical necessity of hypnotherapy 6 sessions was not established by the documentation provided for consideration for this review. There were no medical records discussing participation in prior hypnotherapy sessions, no indication of whether or not she's received prior hypnotherapy sessions and if so how many and if there was functional improvement as a result. Because the medical necessity of this request is not established the utilization review determination for non-certification is upheld.

Monthly medication management, quantity 6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Stress and Mental Illness Chapter, Office Visits.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398 B Referral and 405 office visits.

Decision rationale: ACOEM chapter 15 page 398 B, Referral. Specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities some mental illnesses are chronic conditions, so establishing a good working relationship the patient may facilitate a referral for the return-to-work process. Treating specific psychiatric diagnoses are described in other practice guidelines and texts. It is recognized that primary care physicians and other non-psychological specialists commonly deal with and try to treat psychiatric conditions. It is also recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than 6 to 8 weeks. The practitioner should use his or her best professional judgment in determining the type of specialist. Issues regarding work stress and person-job fit may be handled effectively with talk therapy through a psychologist or other mental health professional. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy. Chapter 15, page 405. The ACOEM guidelines state that the frequency of follow visits may be determined by the severity of symptoms, whether the patient was referred for further testing and/or psychotherapy, and whether the patient is missing work. These results allow the physician and patient to reassess all aspects of the stress model (symptoms, demands, coping mechanisms, and other resources) and to reinforce the patient's supports and positive coping mechanisms. Generally, patients with stress-related complaints can be followed by a mid-level practitioner every few days for counseling about coping mechanisms, medication use, activity modification, and other concerns. These interactions may be conducted either on site or by telephone to avoid interfering with

modified for full duty work if the patient has returned to work. Followed by a physician can occur when a change in duty status is anticipated (modified, increased, or forward duty) at least once a week if the patient is missing work. Decision: The medical necessity of the request for 6 sessions of psychiatric treatment was not established by the documentation provided for review. The patient has, at the time that this request was filed, been authorized for 6 follow-up visits. The patient is stable on her current psychiatric medication regime of Remeron and Effexor. She has not completed all of these sessions at the time the request was filled in fact most of the request was still unused at the time. The official disability guidelines state that: "primary care physicians and other non-psychological specialists commonly deal with and try to treat psychiatric conditions. It is also recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, are referred to a specialist after symptoms continue for more than 6 to 8 weeks." Based on the most recent documentation provided, the patient is currently stable on her psychiatric medications and does not have severe or complicated psychiatric symptomology of schizophrenia or severe depression. Medication follow-up can often be followed by primary medical physicians. The patient reports no current side effects from the medications, while psychiatric consultation and follow-up may be necessary for this patient the frequency of one time per month for a period of 6 months exceeds what would be medically necessary. Routine psychiatric follow-up is often at an interval less frequent. In addition after a few months the medical necessity of the treatment should be reassessed to see if it still needed. Because this request is excessive in frequency and duration the medical necessity is not established and the utilization review determination for non-certification is upheld . This is not to say that the patient does not, or does, require any psychiatric follow-up only that the request is excessive as presented.