

Case Number:	CM15-0095039		
Date Assigned:	05/21/2015	Date of Injury:	06/14/2009
Decision Date:	06/25/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/18/2015

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 56 year old female, who sustained an industrial injury on June 14, 2009. The injured worker was diagnosed as having adjustment disorder with depressed, anxious mood and depressive disorder, lumbosacral spondylosis without myelopathy, lumbosacral radiculitis, ankle sprain, and enthesopathy of unspecified site, hypertension and hypothyroidism. Treatment to date has included right ankle surgery and medication. Currently, the injured worker complains of right ankle and foot pain, low back pain occasionally radiating to the lower extremities, and increasing depression. The Psychiatric Progress report dated March 27, 2015, noted the injured worker reporting her increasing depression was attributed to having stopped her psychotropic medications, and currently not taking any antidepressants. The injured worker's current medications were listed as Lisinopril-Hydrochlorothiazide, Vicodin, Levothyroxine, Prilosec, Meloxicam, and Neurontin. The mental status examination was noted to describe her mood as sad, with restricted affect and fair insight. The treatment plan was noted to include the medications Wellbutrin and Silenor, with Fetzima, Celexa, Trazodone, and Vibryd discontinued, labs pending, and notation that the injured worker could benefit from weekly cognitive behavioral psychotherapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive behavioral therapy x 6: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23.

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: 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 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: A request was made for cognitive behavioral therapy 6 sessions; the request was non-certified by utilization review with the following rationale provided: "the clinical information submitted does not provide documentation indicating that the patient has had significant improvement or functional improvement with the previous cognitive behavioral therapy sessions to warrant additional sessions at this time." This IMR will address a request to overturn that 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 session including objectively measured functional improvement. The provided medical records contain multiple mentions by different treating providers indicating the patient is experiencing moderate levels of depression. There are multiple treatment progress notes from psychiatric providers discussing her medication use and desire to get back onto Wellbutrin having tried others that were less successful. No treatment progress notes from any psychologists were found indicating prior psychological, i.e. cognitive behavioral therapy, treatments have been provided. According to a March 6, 2014 psychiatric evaluation it is noted the following: "she reports experiencing depression, anxiety, anger and irritability she has been experiencing significant decline and sleep, energy level, concentration and fluctuation in appetite. She denies suicidal ideations, homicidal ideations, auditory hallucinations,

visual hallucinations or tactile hallucinations. She is not been provided with any psychiatric treatment under work compensation and currently is receiving treatment for [REDACTED]."

She's been diagnosed with: Adjustment disorder with depressed, anxious mood; depressive disorder not otherwise specified (Initial diagnosis). It is noted that "in addition to medication management, she can benefit from weekly cognitive behavioral therapy." As best as can be determined, although not definitively, it does not appear that the patient has received any psychological treatment although she has received psychiatric medication management. There is significant documentation of the patient suffering from psychological symptoms including moderate depression and anxiety as well as the possibility of a somatoform disorder. There are several detailed evaluations of her psychological/psychiatric condition. It appears very likely that the utilization review discussion of its decision to not approve the requested treatment is based on the finding in the psychiatric treatment progress notes and these in fact do not reflect significant patient improvement as a result of treatment but because this request is for psychological cognitive behavioral treatment those findings would not apply. While it would be beneficial to know definitively whether or not she has received psychological treatment because the preponderance of evidence appears that she is not then this request for 6 cognitive behavioral therapy sessions appears to be reasonable and medically appropriate. According to the MTUS guidelines and initial course of psychological treatment should consist of 3 to 4 sessions. The official disability guidelines recommend an initial brief course of treatment consisting of 4 to 6 sessions. Additional sessions may be offered contingent upon the establishment of medical necessity based on documented patient response to the brief initial treatment trial with noticeable patient benefit including functional improvement and evidence of a patient making progress in treatment. Because the request is medically necessary, reasonable and appropriate the utilization review determination for non-certification is overturned.