

<b>Case Number:</b>	CM14-0001460		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	04/11/2003
<b>Decision Date:</b>	07/28/2014	<b>UR Denial Date:</b>	12/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant was injured on 04/11/03. He has a history of low back pain. Eye movement desensitization and reprocessing for 12 sessions has been requested and is under review. A nurse practitioner, [REDACTED] on 06/26/13, complained of low back pain, and left leg numbness with anxiety, evaluated him. His anxiety and depression were through the roof. He had tried a higher dose of Lexapro for a short time but did not notice a big difference. He wanted to switch back to Zanaflex from baclofen. He had some reduced anxiety on Zanaflex. He was on multiple medications including Suboxone, Lexapro, valproic acid, verapamil, baclofen, Arthrotec, alprazolam, temazepam, Protonix, Rozerem, MiraLAX, lovastatin, Benadryl, and topical steroid. He was using a spinal cord stimulator 3 times a week for pain flares. He was in mild distress. He had painful and limited lower back and tenderness. There are no pathologic neurologic signs. His medications were changed. On 09/26/13, he was seen again and was doing a little better. He was going to cognitive behavioral therapy group and was profiting from it. He was going to AA weekly. Random drug screening was done that day. His medications were unchanged. On 12/10/13, he was evaluated and was doing a little better. He was walking 1 or 2 miles every day and getting out more. The increased dose of alprazolam was helpful to control his significant anxiety since his injury. He had anxiety and PTSD due to pain. He stated he had total nervousness. He was to continue his current medications. He had a chronic pain evaluation on 02/05/14. He had an existing authorization for 6 sessions of eye movement desensitization and reprocessing treatment for his industrial trauma. He was injured while walking on a hill near a pump station and a pipe on a chain hit him in the chest and rolled him down the hill in a ball. He had flashbacks of the incident. He wanted the spinal cord stimulator removed because it was causing anxiety. He was experiencing a chronic pain disorder as well as severe anxiety, depression, panic attacks and PTSD. He also has a diagnosis of bipolar disorder. He is a

veteran. He also had an abusive childhood. On 03/25/14, he complained of low back pain and left leg numbness with anxiety. He was benefitting from his EMDR treatments, 6 sessions had been approved, and he had had four of them. He appeared well and well nourished. He was tender throughout the lumbar spine. He was to continue treatment with EMDR (eye movement desensitization and processing).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Eye movement desensitization and reprocessing, 12 sessions: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress, EMDR.

**Decision rationale:** The history and documentation do not objectively support the request for 12 sessions of Eye movement desensitization and reprocessing (EMDR). The California Medical Treatment Utilization Schedule (MTUS) is silent on this treatment. The Official Disability Guidelines (ODG) state "EMDR may be recommended as an option. Eye movement desensitization and reprocessing (EMDR) is becoming a recognized and accepted form of psychotherapy for posttraumatic stress disorder (PTSD). Yet, its mechanism of action remains unclear and much controversy exists about whether eye movements or other forms of bilateral kinesthetic stimulation contribute to its clinical effects beyond the exposure elements of the procedure. (Servan, 2006) (Seidler, 2006) (Macklin, 2000) EMDR is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories. The developer of EMDR, psychologist [REDACTED], proposes the idea that EMDR facilitates the accessing and processing of traumatic memories to bring these to an adaptive resolution. The possibility of obtaining significant clinical improvements in PTSD in a few sessions presents this treatment method as an attractive modality worthy of consideration. During EMDR, the patient is asked to identify: (1) a disturbing image that encapsulates the worst part of the traumatic event; (2) associated body sensations; (3) a negative self-referring cognition (in concise words) that expresses what the patient "learned" from the trauma; (4) a positive self-referring cognition that the patient wishes could replace the negative cognition. The patient is then asked to hold the disturbing image, sensations, and the negative cognition in mind while tracking the clinician's moving finger back and forth in front of his or her visual field for about 20 seconds. In successive tracking episodes, the patient concentrates on whatever changes or new associations have occurred. Tracking episodes are repeated according to the protocol until the patient has no further changes. More tracking episodes then reinforce the positive cognition. Between sessions, the patient is directed to keep a journal of any situations that provoke PTSD symptoms and of any insights or dreams about the trauma. The sessions required may be as few as two for uncomplicated PTSD. More sessions are required for multiple or more complicated trauma. Standard cognitive behavioral therapy (CBT) rating scales are used throughout the sessions to document changes in the intensity of the symptoms and the negative cognition, and

the patient's belief in the positive cognition. The patient only needs to tell the therapist the concise negative and positive cognitions and whether (and what) cognition, image, emotion, or body sensation has changed. The therapist is close to the patient and maintains direct eye contact as part of the protocol. This fosters a non-directive interaction that usually detects adverse reactions, which the therapist helps the patient manage with cognitive techniques. EMDR processing is internal to the patient, who does not have to reveal the traumatic event. The protocol allows for substitution of left-right alternating tone or touch as alternatives in place of the eye movements. Studies attempting to ascertain the relative contribution of the eye-movement component have suggested comparable treatment results with or without eye movements, indicating that this aspect of the treatment protocol may not be critical to effectiveness. (VA/DoD, 2004) EMDR therapy for PTSD provides more rapid results than cognitive behavioral therapy (CBT), an RCT suggests. Although there were no significant between-group differences in Impact of Event Scale-Revised (IES-R) scores at the end of the study, the response pattern showed a significantly sharper decline in PTSD symptoms at 6-weeks for those receiving EMDR therapy. The conclusion is that both treatments are equally effective, and the patient and clinician can choose a certain treatment based on their preferences, according to the authors. If a patient values fast symptom reduction, EMDR is the treatment of choice. If a patient feels the need to make meaning out of the traumatic experience and learn from it, brief eclectic psychotherapy is the best choice." In this case, the medical necessity of 12 sessions of EMDR prior to a successful trial has not been clearly demonstrated. The claimant reported improvement after completing 4 of 6 approved sessions. However, the results of the last two sessions is unknown, especially whether additional improvement was noted. The number of sessions needed for an individual varies widely.