

Case Number:	CM14-0173122		
Date Assigned:	10/23/2014	Date of Injury:	12/04/2008
Decision Date:	11/25/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/20/2014

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 licensed in clinical psychology 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:

According to the records provided for this IMR, this 44 year-old female patient reported an industrial injury that occurred on December 4, 2008. Her primary injury occurred when a wheel on a cart containing pizza dough broke loose and the cart fell on her neck and back with the dough falling on her shoulders, she was found pinned to the floor where she had been over an hour and needing help to get up. This resulted in significant injury/pain. She was maintaining a second job for [REDACTED] and reportedly sustained an injury as well at this location. This injury reportedly occurred while she was reaching to retrieve ice cubes from an icemaker and experience severe low back pain. The injury reportedly has affected her neck, back, bilateral arms, shoulders, and legs. There is a continuous trauma injury from May 27, 2007 through December 7, 2008 with additional physical and psychiatric complaints in obstetrics and gynecology. There is also a work harassment issue. The relative contributions of these injuries was intermingled. An incomplete and only partial list of her medical diagnoses include: status post anterior cervical fusion and discectomy C4-C5 and C5-6; status post laminectomy, discectomy and decompression at L5/S1. This IRM will focus on her psychological/psychiatric symptoms/treatment. In November 2009 she received a diagnosis of reactionary depression/anxiety. In March 2010 she reported difficulty sleeping due to increased pain, restlessness and nervousness with heart palpitations, muscle tension, sweating sensations in her hands and body. At that time she was diagnosed with: Major Depressive Disorder, Single Episode, Moderate; Generalized Anxiety Disorder; Female Hypoactive Sexual Desire Disorder Due To Chronic Pain; Sleep Disorder Due To Chronic Pain, Insomnia Type; Pain Disorder Associated with Both Psychological Factors and a General Medical Condition; Psychological Factors Affecting Medical Condition, G.I. Disturbance. In January 2011 a comprehensive psychological QME was conducted and it was recommended that she continue to receive

psychotherapy and psychotropic medication. She has been prescribed Celexa, Wellbutrin, Prazosin, and Trazodone, this list may not be current. She appears to have first presented for psychological treatment in March 2010. There is evidence of psychological treatment throughout 2010, 2011, and 2012 to July, 2013. In 2014 psychological treatment was received March through October and then intermittently in May, July and August 2014. It is possible that additional treatment was provided. The information regarding her prior psychological treatment is unclear, confusing and inconsistently reported. In May 2014, she reports that she saw the psychologist only two or three times and attended individual psychotherapy with a psychological assistant only once, and that she was attending group therapy initially twice per week but that the frequency was decreased only once a month after her surgery because it was too difficult to attend more frequently. Progress notes suggest more frequent attendance. In May 2014 she reported her psychological symptoms resulted in inability to perform activities of daily living and she has lost motivation to keep up with household chores. She avoids going to the supermarket out of fear that somebody is going to knock into her or bump her. She feels that she may be at risk for an accident due to impaired cognition and nervous behavior. Psychological testing reflects a very severe degree of reported depression along with moderate anxiety symptoms. Following her surgery she still has constant neck and low back pain with bilateral upper and lower extremity radiation numbness. A stress reaction of vaginally bleeding has been attributed to the difficult situation she has been placed in with her pain condition, disability, loss of her home, concern about future recovery in economic hardship associated with prolonged period of unemployment and lifestyle changes due to physical limitations. QME treatment recommendation stated that there is "no question that the patient requires intensive psychotherapeutic intervention in concert with psychopharmacological component to be managed by a psychiatrist." It was further concluded that she be offered a course of combined group and supportive individual therapy 2x a month and group psychotherapy weekly for 7 months, then tapering down to twice monthly." She stated that she has participated in only "minimal psychological treatment" because she does not feel safe taking public transportation and her boyfriend has to take time off work to drive her, so the needed treatment should be found that is closer to her home. In contrast, a psychotherapy treatment progress note from August 2014 states that the patient should continue attending groups weekly and finds the skills learned helpful in managing emotional symptoms. She reports continuing to feel sad and anxious and continues to worry and emotional sensitivity. Treatment goals are listed as: decreasing frequency and intensity of depressive and anxious symptoms and improving duration and quality of sleep. Progress listed to date is noted as: "patient has made some progress towards current treatment goals as evidenced by some improvement in managing emotional symptoms." A previous note from July 2014 from the same provider reports identical treatment goals with progress listed as "some improvement in ability to manage her anxious symptoms and sleep and improvement in nightmares." Similar progress notes are found dating back to 2011. A request for medical hypnotherapy and relaxation training one time a week for a weeks and in additional request for group medical psychotherapy once a week for eight weeks was made and both were non-certified. According to the UR determination: "there is no comprehensive assessment of psychological treatment completed to date or the patient's response thereto submitted for review. There is no indication that the patient has undergone any previous individual psychotherapy with benefit. Additionally, current evidence-based guideline support group psychotherapy and hypnotherapy as an option for patients with a diagnosis of PTSD. Submitted records failed to document a diagnosis of PTSD for this patient."

IMR ISSUES, DECISIONS AND RATIONALES

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

Medical Hypnotherapy/Relaxation Training 1xwk x 8wks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines Stress Related Conditions: Stress Management Techniques

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 400. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress Chapter, topic hypnosis, October 2014 update.

Decision rationale: The CA-MTUS guidelines are nonspecific for hypnosis, however ODG says that it is a therapeutic intervention that may be an effective adjunctive procedure in the treatment of post-traumatic stress disorder PTSD and 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. The ACOEM states that relaxation therapies can be prevented to or helpful for patients in chronically stressful conditions, or they may even be curative for individuals with specific physiologic responses to stress. Relaxation techniques include meditation, relaxation response, and progressive relaxation. This request is for an unspecified quantity of sessions of medical hypnotherapy and relaxation training. Requests for treatment without a stated quantity are the equivalent of requesting an open ended quantity sessions. No specific rationale for the request was provided addressing why she needs this treatment modality in addition to CBT was made. Relaxation training is a part of CBT and if needed should be provided during the CBT session. This patient appears to have had prior hypnosis/relaxation therapy and yet there were no specific progress notes that addressed this treatment intervention - e.g. whether or not she achieved states of relaxation, the depth of hypnotic trance that was achieved, if this modality resulted in diminished pain and improved functionality in activities of daily living. There was no indication about efforts to have the patient learn how to use these techniques independently or an expectation of how many sessions would be needed to complete her treatment. The patient appears to have had extensive prior treatment for several years off and on but the total number of sessions was not provided and could not be estimated. Treatment notes were inconsistent with regards to her prior psychological treatment. The patient's self-report states that she has received minimal treatment and yet progress notes indicate regular ongoing care has occurred on a weekly basis for many years. The patient indicates that she has not able to attend weekly sessions frequently due to transportation problems and yet weekly therapy is still being requested. Progress notes were found indicating lengthy treatment over a period of several years with the same provider without substantial and sustainable objective functional improvements that would be expected after a prolonged period of treatment. The medical necessity of additional hypnotherapy/relaxation training is not supported as medically necessary by the documentation provided due to exceeding recommended guidelines of 13-20 sessions maximum for most patients and inadequate documentation of objective functional improvements.

Group Medical Psychotherapy (Cognitive Therapy) 1xwk x 8wks: Upheld

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 behavioral interventions, cognitive behavioral therapy, see also psychotherapy guidelines Page. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: According to the MTUS treatment guidelines, psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. 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. With respect to this request, the patient has already had extensive psychological care and treatment over a period of 3 to 4 years and while the total number of sessions has not been provided, it appears to likely exceed the recommended guidelines stated above. Continued treatment is contingent upon objective functional improvements and not solely based on patient symptomology. There was inadequate documentation of the patient achieving objective functional improvements in a progressive manner over the course of treatment. Treatment goals were static and did not change from month-to-month. There was no indication of treatment goals being met with new treatment goals replacing the ones that have been accomplished. There was no estimated dates provided of when treatment goals would be reached. There are inconsistencies with respect to the number and frequency at which the patient is participating in treatment as progress notes indicate weekly treatment and yet the patient's self-report suggests once a month due to transportation problems. The patient clearly states she cannot attend weekly therapy and yet weekly therapy is being requested. The requested treatment is not supported as being medically necessary by the documentation provided and the request to overturn the utilization review non-certification determination is denied.