

Case Number:	CM13-0006218		
Date Assigned:	08/26/2013	Date of Injury:	02/22/2000
Decision Date:	01/13/2014	UR Denial Date:	07/18/2013
Priority:	Standard	Application Received:	08/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Psychiatry 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 physician 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.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a case involving a 54 year old female. She first worked for the [REDACTED] in 1990. She had a slip-and fall injury at work in 1992 that led to problems with her right knee: She underwent right knee arthroscopic surgery in 1992, 1996 and 2000. As a result of favoring her right knee for several years, she developed left knee problems. She states that her left knee problems precipitated a fall in 2003, which resulted in injuries to her right shoulder, wrist, hips and lower back. When she- was first seen at [REDACTED] in July 2005, she complained of decreased concentration, depression, anxiety, and perceptual disturbances, primarily auditory hallucinations. She was seen in therapy from September 2005 to June 2005, during which time, minimal improvement was observed. In March 2009, she continued to complain of ongoing pain in the knees, right shoulder, right wrist, hips and lower back. She had been diagnosed with bilateral carpal tunnel syndrome and was awaiting approval for release surgery. She reported that she often felt sad, depressed, anxious, angry, irritable and worried.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychological testing, 5 units: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-101.

Decision rationale: The Chronic Pain Medical Treatment Guidelines, 8 C.C.R. §§9792.20 - 9792.26, page(s) pgs. 100-101. has the following to state about Psychological evaluations: Recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. (Main-BMJ, 2002) (Colorado, 2002) (Gatchel, 1995) (Gatchel, 1999) (Gatchel, 2004) (Gatchel, 2005) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a Psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. (Gatchel, 1999) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. (Goldberg, 1999) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. (Linton, 2002) Other studies and reviews support these theories. (Perez, 2001) (Pulliam, 2001) (Severeijns, 2001) (Sommer, 1998) In a large RCT the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. (Lin-JAMA, 2003) See "Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients" from the Colorado Division of Workers' Compensation, which describes and evaluates the following 26 tests: (1) BHI 2nd ed - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory [has been superseded by the MBMD following, which should be administered instead], (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 - Brief Battery for Health Improvement, (9) MPI - Multidimensional Pain Inventory, (10) P-3 - Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Sympt

The request for Individual psychotherapy times twelve (12) sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

Decision rationale: The Chronic Pain Medical Treatment Guidelines 8 C.C.R. §§9792.20 - 9792.26, page 23 has the following to state about Behavioral interventions: Recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence.

See also Multi-disciplinary pain programs. ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone: - Initial trial of 3-4 psychotherapy visits over 2 weeks - With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions) The guidelines are very clear that the total number of visits is 6-10. As such, per guideline, the request for 12 visits exceeds the guideline and is not medically necessary.

The request for Medication management times four (4) sessions: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 27, 107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress, office visits, and American Psychiatric Association Practice Guidelines Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition DOI: 10.1176/appi.books.978089

Decision rationale: The CA MTUS does not specifically address office visits for psychiatric medication management. The ODG does address office visits as follows: ODG, Mental Illness & Stress, Office Visits. Recommended as determined to be medically necessary; Evaluation and ,management (E&M) outpatient visits to the Offices of medical doctor(s) play a critical role in the Final Determination Letter for IMR Case Number CM13-0006218 5 proper diagnosis and return to function of an injured worker, and they should be encouraged. The American Psychiatric Association Practice Guidelines Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition DOI:

10.1176/appi.books.9780890423387.654001 states the following with respect to therapeutic interventions: "b. Assessing the adequacy of treatment response In assessing the adequacy of a therapeutic intervention, it is important to establish that treatment has been administered for a sufficient duration and at a sufficient frequency or, in the case of medication, dose [I]. Onset of benefit from psychotherapy tends to be a bit more gradual than that from medication, but no treatment should continue unmodified if there has been no symptomatic improvement after 1 month [I]. Generally, 4-8 weeks of treatment are needed before concluding that a patient is partially responsive or unresponsive to a specific intervention [II]." [REDACTED] a board certified psychiatrist, on 7-9-13 stated the patient would likely benefit from psychiatric medication. Treatment with psychiatric medication is a series of medication trials that must be undertaken, modified and monitored over long periods of time with multiple visits by national standards of care. As such, four medication management visits are medically necessary. To underscore this point, it is very likely that many more than four medication management visits over time would also be medically necessary.