

Case Number:	CM13-0019331		
Date Assigned:	04/25/2014	Date of Injury:	04/19/2004
Decision Date:	06/10/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	09/03/2013

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 Psychiatry, Neurology, and Addiction Medicine, has a subspecialty in Geriatric 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 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 records reviewed include 594 pages of medical and administrative records. The injured worker is a 52-year-old male whose date of injury is 04/19/2004, who suffers from major depressive disorder, single episode, moderate and pain disorder associated with both psychological factors and a general medical condition. He worked as a paraeducator dealing with combative students. He had a prior left wrist injury, which was then reinjured on 04/19/04 when it was yanked by a then 17-year-old who weight around 280 pounds. He felt a pop and the tendon was apparently severed. He subsequently underwent surgery only to find out that it could not be repaired. He developed anger and constant pain, suicidal ideation without attempt, erectile difficulty, and weight gain over time where at one point he weighed up to 500 lbs. He was diagnosed with cervical diseased disc with left sided radiculopathy, left wrist arthropathy status post-surgery with complications of complex regional pain syndrome, myofascial syndrome, and reactive sleep disturbance. Psychotherapy was recommended in 12/08 in a psychological report by [REDACTED]. He has since been seeing [REDACTED] in psychotherapy. The primary physician's progress reports note symptoms of depression as hopelessness, anxiety, rumination, and lack of motivation. The progress reports from then up to 08/08/13 have consistently shown no functional improvement evidenced by lack of improvement in quality of life/energy, and lack of change in coping behavior with isolation, avoidance, and stonewalling. In April 2013, the patient apparently experienced side effects from the weight loss medication (Suprenza) given to him by [REDACTED], during his weight loss management treatment. This resulted in a suicide attempt, in which he was placed on a 5150, after which he denied further suicidal ideation. On 10/16/13 a special report by [REDACTED], MD notes that the psychotherapy sessions were helpful to the patient in managing his stress,

allowing him to be able to perform therapeutic exercises and activities to achieve functional restoration, and that the patient reported "excellent improvement" in mood and daily function which allowed him to learn how to better tolerate his chronic pain. ██████ felt that these factors greatly contributed to "some level of overall decreased pain". On 11/05/13, ██████ submitted a psychological status report. Testing on 08/08/13 revealed a Beck Depression Inventory (BDI) score of 37 (severe), pain catastrophizing scale (PCS) score of 41, indicating delayed recovery due to catastrophizing. He worries all the time about whether the pain will end. Both scores are lower than his last assessment in May 2013. On 08/15/13, the patient described old coping behaviors and expressed frustration, hopelessness, and helplessness after an argument. The medications at that time were Neurontin, Norco, Opana, and topiramate. There is no mention of the patient having a trial of an antidepressant or anxiolytic. No further records were provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

SIX PSYCHOTHERAPY SESSIONS: Upheld

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

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

Decision rationale: The Chronic Pain Guidelines indicate that behavioral interventions are recommended. The guidelines also indicate that the initial therapy for "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. The provider should consider separate psychotherapy cognitive behavioral therapy (CBT) referral after four (4) weeks, if there is a lack of progress from physical medicine alone. An initial trial of three to four (3-4) psychotherapy visits over two (2) weeks, and with evidence of objective functional improvement, a total of up to six to ten (6-10) visits over five to six (5-6) weeks (individual sessions) is recommended. According to the records submitted for review, the patient has had psychotherapy since at least April 2014. The progress reports overall show lack of significant functional improvement as evidenced by the fact that reports describe him as lacking improvement in quality of life/energy, and lack of change in coping behavior with isolation, stonewalling, and avoidance. It is not until October 2013 that one sees some improvement in his Beck Depression Inventory (BDI) score; however, he is still rated in the severe range for depression. It is important to note that according to the documentation provided, this patient does not appear to have been afforded a trial of an antidepressant or anxiolytic. In addition, there are no current records to show what functional improvements, if any, have been made to warrant further psychotherapy. This patient appears to continue to use old coping skills despite what was then several months of psychotherapy. He has also used greater than ten (10) visits without evidence of significant functional improvement. Therefore, this request is not certified.