

<b>Case Number:</b>	CM14-0004205		
<b>Date Assigned:</b>	02/03/2014	<b>Date of Injury:</b>	09/08/1999
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	01/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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 Psychiatry, and is licensed to practice in Illinois. 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:

This is a 61 year old male who was injured in September of 1999. The patient was hospitalized in October of last year and has complained of moderate to severe pain. He is diagnosed with Major Depression, Severe, without Psychosis. The provider is requesting Individual cognitive therapy twice weekly times 3 months, group therapy twice weekly times 3 months, monthly psychopharmacology management times 3 months, home care assistance, Wellbutrin 150 mg daily, Remeron 15 mg daily, Risperdal 0.5 mg at hs, and Neurontin 300 mg (unknown frequency). Coverage for all of the above services except the Wellbutrin, Remeron and psychopharmacology has been denied. This is an independent review of the previous decision to deny coverage for individual cognitive therapy, group therapy, home care assistance, Risperdal and Neurontin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **INDIVIDUAL COGNITIVE BEHAVIORAL THERAPY 2 TIMES A WEEK FOR 3 MONTHS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 23

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

**Decision rationale:** The MTUS Chronic Pain Guidelines indicates an initial trial of 3-4 psychotherapy visits over 2 weeks and with evidence of objective functional improvement, a total of up to 6-10 visits over 5-6 weeks. While it is not certain how many sessions the patient has had, he has been receiving ongoing treatment for quite some time and the request is beyond the parameters recommended by the MTUS Chronic Pain Guidelines. As such the requested sessions are not medically necessary and appropriate.

**RISPERDOL 0.5MG, #30:** Overturned

**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 APA Guidelines

**Decision rationale:** The MTUS Chronic Pain and ACOEM Guidelines are nonspecific concerning recommendations regarding neuroleptic medications. The records reviewed indicate that the patient was hospitalized with auditory command hallucinations telling him to commit suicide. APA Practice Guidelines indicate that "For patients who exhibit psychotic symptoms during an episode of major depressive disorder, treatment should include a combination of antipsychotic and antidepressant medications". Wellbutrin and Remeron have already been authorized; the records and evidence based guidelines indicate an adjunctive antipsychotic as the standard of care and as such Risperdal is integral to patient safety. Consequently, the request is medically necessary and appropriate.

**NEURONTIN 300MG:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 18-19

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

**Decision rationale:** This medication appears to be recommended for chronic pain. The patient has been on it for a considerable period of time and the records indicate that he still struggles with his pain. It has been approved in the past and the records show no evidence of any change in his condition which would warrant discontinuation of this medication. The request is not medically necessary and appropriate.

**HOME CARE ASSISTANCE 24/7 BY PSYCH TEACH OR LVN:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, HOME HEALTH, 51

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51. Decision based on Non-MTUS Citation CMS Guidelines

**Decision rationale:** Regarding Home health services, the MTUS Chronic Pain Guidelines indicate "Medical treatment does not include homemaker services like shopping, cleaning and laundry." The chart indicates that this patient has been receiving these services for the purpose of assisting with meals, transportation and cleaning. The patient is ambulatory although he needs assistance with a cane. There is no specific guideline for use of these services for psychiatric condition but there is no evidence that these services are essential to the patient's recovery from the psychiatric standpoint and such services are beyond the scope of those required for most psychiatric conditions. CMS furthermore does not reimburse for services related to meal preparation, housework and transportation. The request is therefore not medically necessary and appropriate.

**GROUP THERAPY 2 TIMES A WEEK FOR 3 MONTHS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 23

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation APA Guidelines

**Decision rationale:** APA Practice Guidelines indicate that "Group psychotherapy is widely practiced, but research on its application to major depressive disorder is limited." In this particular case the provider did not submit a rationale for the request for group therapy. Given the lack of evidence indicating its use for Major Depressive Disorders and the lack of a specific indication in this particular case, the request is not medically necessary and appropriate.