

<b>Case Number:</b>	CM14-0005209		
<b>Date Assigned:</b>	02/14/2014	<b>Date of Injury:</b>	02/19/2004
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	12/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2014

### 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 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:

Records reviewed include 529 pages of medical and administrative records. The injured worker is a 44 year old female whose date of injury is 02/19/2004. She had been employed as a dental hygienist and she developed swelling and numbness in her right hand due to her continual job duties. Her diagnosis is sprain and strain shoulder and upper arm, psychiatric diagnoses are major depressive disorder, anxiety disorder due to general medical condition, and pain disorder. Medications include Pristiq 100mg, lamotrigine, Baclofen and Exalgo for pain management, prescribed by [REDACTED]. She first noticed the onset of depression around the end of 2004. In 2007 she moved to a remote part of [REDACTED] but could not receive California worker's comp services and she sought psychiatric services on her own. Her GYN prescribed Cymbalta and methadone. She ultimately moved back to California. Her depression worsened, becoming the most severe around July 2009 when she attempted suicide by ingesting Methadone, Lyrica, Amitriptyline, Cymbalta, and Oxycontin. At that time she was started on Lamictal, Pristiq and Cytomel. On 04/11/13 there was a comprehensive psychiatric evaluation and psychological testing which gave an overview of the 2 prior years. It described the patient's symptoms as depressed mood, crying, decreased personal hygiene/appetite/memory, increased weight, sleep disturbance, anhedonia, hopelessness, and recent suicidal ideation. She began psychotherapy in 11/12 and continued until this report. She denied further suicidal ideation. Her Beck Anxiety Inventory score=17 (moderate) and Beck Depression Inventory=31 (severe). CBT was recommended along with changes in her medication regimen to include Effexor XR and gabapentin. It is interesting to note in this report that there were 2 episodes of sub-rosa surveillances conducted. The first in 2010 showed that the patient may be less psychiatrically impaired than she purported herself to be expected for her then GAF of 59, and were it not for her being on Pristiq, Lamictal, and Cytomel, the evaluator might have considered her to be

malingering. The next one in 2012 showed the patient pushing a stroller while manipulating 2 dogs on leashes, sporting 6 new tattoos, and smiling and chatting with others. These activities were considered to be in opposition to someone claiming to suffer from severe upper extremity pain. In 2012 [REDACTED] started her on Lithium for pain which also worked for her stress, insomnia, major depression, major anxiety, and suicidal thoughts. In 09/13 she was described as happy and her depression as stable. She most recently presented on 01/09/14 for follow up with [REDACTED]. She had limited motion in the left upper extremity and nerve banding irritation. She suffered from chronic complex regional pain syndrome, chronic pain disorder, major depressive disorder with history of suicide attempt x1, status post thoracic outlet syndrome and status post surgical release with residual symptoms, status post left scalene muscle release on the left side with residuals, failed epidural steroid injection, and failed sympathetic blocks. [REDACTED] noted that the patient had a depressive overlay due to her chronic pain. Notes from her prior visit of 12/09/13 mention her following up with psychiatry, but it is unclear what the nature of that was.

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

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

#### **PSYCHIATRIC EVALUATION, 12 VISITS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment. Decision based on Non-MTUS Citation ODG) Official Disability Guidelines, Psychological Treatment.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions/ Psychological Treatment Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Stress related conditions, psychological evaluation.

**Decision rationale:** The patient has a history of depression beginning around the end of 2004. She suffered from chronic pain, and was treated with antidepressants and psychotherapy. There is nothing in records provided describing the rationale for necessity of psychotherapy or for this current request. There is no documentation of the number of sessions she received to date however if she has been receiving psychotherapy since around 2012 it appears that she is beyond the 6-10 visits recommended by CA-MTUS guidelines below. In addition, there is no evidence of objective functional improvement (e.g. metrics). Per ODG below, these evaluations should determine if further interventions are indicated. There is no evidence that these occurred, nor are there metrics provided other than those mentioned in the report of 04/11/13. This request is therefore not medically necessary and appropriate. Per CA-MTUS 2009, chronic pain guidelines, behavioral interventions are 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. 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 Cognitive-Behavioral Therapy (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 Per ODG psychological evaluations are 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 subacute and 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. Note: Psychometrics are very important in the evaluation of chronic complex pain problems, but there are some caveats. Not every patient with chronic pain needs to have a psychometric exam. Only those with complex or confounding issues. Evaluation by a psychologist is often very useful and sometimes detrimental, depending on the psychologist and the patient. Careful selection is needed. Psychometrics can be part of the physical examination, but in many instances this requires more time than may be allocated to the examination. There are many psychometric tests with many different purposes. There is no single test that can measure all the variables. Hence a battery from which the appropriate test can be selected is useful. The request is not medically necessary and appropriate.