

Case Number:	CM14-0105885		
Date Assigned:	07/30/2014	Date of Injury:	04/12/2010
Decision Date:	11/13/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/09/2014

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 & Neurology, 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:

Records reviewed include 34 pages of medical and administrative records. The injured worker is a 65 year old male whose date of injury is 04/12/2010. He underwent a lumbar fusion at L3-L4 with left L4 hemilaminectomy and foraminotomy on 10/15/2010. On 08/09/2011 AME psychology evaluation recommended that the patient be seen by a psychiatrist, that a total of 10-12 sessions should suffice to initiate SSRI medications, and that he would benefit from 10-15 CBT sessions. On 10/02/2012 he underwent a psychiatric evaluation and psychological testing with [REDACTED] (psychiatrist?). He was diagnosed with pain disorder with psychological factors and general medical condition, major depressive disorder severe without psychosis, anxiety disorder due to general medical condition, and cannabis, cocaine, and methamphetamine abuse in full sustained remission (per patient's history). Pain, anxiety, and sleep disturbance were targets for psychiatric treatment. He was prescribed lorazepam, venlafaxine ER, and zolpidem ER. It appears that the last time he saw [REDACTED] was in 11/2013, he continued to show anxiety and depression. A physical medicine follow up visit of 06/06/14 with [REDACTED] shows the patient's pain level is 4/10 in the low back radiating to both leg, increased over the last several weeks. He reported difficulty sleeping over the last 2 months. His medications for sleep and depression had been discontinued due to denial of authorization to see [REDACTED]. He was positive for anxiety and depression. The psychiatric treatment plan was to prescribe Effexor and may titrate to three tablets of 75mg QD and continue Ativan 1mg BID for anxiety. He was prescribed Trazodone 50mg one to two QHS as needed for sleeplessness due to pain, anxiety, and depression.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychiatrist Consult Only: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

Decision rationale: The patient is said to have depression and anxiety, however no symptoms are given objectively or subjectively to describe his condition. It is unclear if he ever received the CBT sessions recommended above. There is inadequate documentation to support the request for a psychiatric consultation; therefore I recommend noncertification at this time. CA-MTUS does not address psychiatric evaluations. Per ACOEM, specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities. Some mental illnesses are chronic conditions, so establishing a good working relationship with the patient may facilitate a referral or the return-to-work process. Treating specific psychiatric diagnoses are described in other practice guidelines and texts. It is recognized that primary care physicians and other nonpsychological specialists commonly deal with and try to treat psychiatric conditions. It is recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than six to eight weeks. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy. Therefore the request is not medically necessary.