

Case Number:	CM14-0120167		
Date Assigned:	08/06/2014	Date of Injury:	03/09/2007
Decision Date:	09/11/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/29/2014

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 Psychology 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 claimant is a 58 year-old male date of birth 7/26/56 and a date of injury of 3/9/07. The claimant sustained numerous orthopedic and well as internal injuries when he was involved in a motor vehicle accident while working as an investigator for [REDACTED]. In his "Agreed Medical Examination Supplemental Report" dated 5/14/14, [REDACTED] diagnosed the claimant with: (1) Strain cervical spine resolved with mild degenerative disc disease C5-6; (2) Stain lumbar spine status post multiple surgeries with chronic lower back pain; (3) Bilateral shoulder pain with A.C. arthritis and type III acromion; (4) Status post multiple right arm injuries unchanged; (5) Swelling right leg with deep vein thrombosis on coumadin. It is also reported that the claimant developed psychiatric symptoms secondary to his work-related orthopedic injuries. In his "Agreed Medical Examination" dated 2/28/14, [REDACTED] diagnosed the claimant with: (1) Major depressive disorder with panic attacks, mild to moderate; (2) Pain disorder associated wit both Psychological factors and a general medical condition; (3) erectile dysfunction; (4) Breathing-related sleep disorder; (5) History of narcotic dependence; and (5) History of substance induced psychotic disorder April 2003 probably secondary to analgesia overuse with hallucinations, currently in remission and controlled. Additionally, In his RFA dated 6/25/14, treating psychiatrist, [REDACTED], diagnosed the claimant with(1) Major depressive disorder, single episode, severe; and (2) Pain disorder associated with both psychological factors and a general medical condition.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medication management BDI,BAI, (8) 1x every 6 weeks x 52 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Treatment Workers Compensation (TWC) Mental Illness & Stress Procedure.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter 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 proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy.

Decision rationale: Based on the review of the medical records, the claimant began receiving medication management services with [REDACTED] in April 2012 and sees him approximately every 4-6 weeks. Since the claimant continues to require psychotropic medications to manage his psychiatric symptoms, the request for additional medication management visits is reasonable. However, the request for visits for the entire year appears excessive as this period of time does not offer a reasonable amount of time for reassessment of medications, treatment plan, etc. As a result, the request for "Medication management BDI,BAI, (8) 1x every 6 weeks x 52 weeks" is not medically necessary.

Psychotherapy (24) 2x/Month x 52 weeks BAI,BDI (1x every 6 weeks):

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Treatment Workers Compensation (TWC) Mental Illness & Stress.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter Cognitive therapy for depression Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). (Paykel, 2006) (Bockting, 2006) (DeRubeis, 1999) (Goldapple, 2004) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. (Gloaguen, 1998) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. (Corey-Lisle, 2004) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. (Pampallona, 2004) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. (Royal Australian, 2003) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. (Warren, 2005) Delivering cognitive behavioral therapy (CBT) by telephone is as effective as delivering it face-to-face in the short term, and telephone therapy is safe and has a higher patient retention rate. The attrition rate from psychotherapy can exceed 50% due to time constraints, lack of available and accessible services, transportation problems, and cost. Significantly fewer participants receiving telephone CBT discontinued their therapy than did those receiving face-to-face CBT. Both treatment groups showed significant improvement in depression, and there were no significant treatment differences when measured at posttreatment between telephone and face-to-face CBT. However, face-to-face CBT was significantly superior to telephone CBT during the follow-up period. The RCT used 18 sessions of either telephone CBT or face-to-face CBT. (Mohr, 2012) Psychotherapy visits are generally separate from physical therapy visits. ODG Psychotherapy Guidelines: Initial trial of 6 visits over 6 weeks With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions) Other Medical Treatment Guideline or Medical Evidence: APA PRACTICE GUIDELINE FOR THE Treatment of Patients With Major Depressive Disorder Third Edition (2010) Maintenance phase (pg. 19) In order to reduce the

Decision rationale: Based on the review of the medical records, the claimant began treating with psychologist, [REDACTED] in mid 2012 and has been treating with him since that time. Given the claimant's continued symptoms and need for ongoing services, the request for additional maintenance psychotherapy sessions is reasonable. However, the request for one year worth of sessions appears excessive as it does not allow for a reasonable time for reassessment of goals, interventions, modality, etc. As a result, the request for "Psychotherapy (24) two times/Month times fifty two weeks BAI, BDI (one times every six weeks)" is not medically necessary.

