

Case Number:	CM14-0152664		
Date Assigned:	09/22/2014	Date of Injury:	10/06/2011
Decision Date:	10/21/2014	UR Denial Date:	08/18/2014
Priority:	Standard	Application Received:	09/15/2014

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, & Addition 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 131 pages of medical and administrative records. The injured worker is a 64 year old female whose date of injury is 10/06/2011, which involved a fall on cement. Since that time she has been suffering from headaches, memory loss, insomnia, nausea, and anxiety. A PR2 of 03/10/14 by [REDACTED] indicated that patient reported no change in her ongoing symptoms. Medications included Aspirin and Levothyroxine. She was no longer seeing a psychologist. Affect was dull, she was described as rather emotionless with depressed affect. Diagnoses were post-concussion syndrome, sprains and strains of the shoulder and upper arm NOS, and sprains and strains of knee and leg NOS. The treating doctor felt that if she is hypothyroid it may be contributing to her overall depression. In a PR2 dated 04/18/14, the patient's TSH was 0.34 indicating no evidence of hypothyroidism. She reported depression and headaches with feelings of hopelessness. She was now on Effexor XR 75mg daily and reported mood and sleep improvement. She had four sessions of CBT as of 12/2012. Effexor XR has been helping her to "not feel so dead", mood had improved and she was better able to interact more with family. Subsequent to that her affect became more animated with modest improvement. On 07/01/13 she was advised to increase the Effexor dose but she refused to do that or try other medications. She indicated that she did not wish to be on medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychotherapy x 12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cognitive behavioral therapy (CBT)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions, Page(s): 23 of 127.

Decision rationale: MTUS recommends 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. See also Multi-disciplinary pain programs. Official Disability Guidelines (ODG), cognitive behavioral therapy (CBT) guidelines for chronic pain recommends a 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 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 (individual sessions). Records indicate that the patient had received four CBT sessions as of December 2012; however, the symptoms being treated were not adequately described nor were the responses to treatment. Due to lack of documentation to support evidence of objective functional improvement, this request is not medically necessary.

Consultation with a psychiatrist: Upheld

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

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

Decision rationale: MTUS does not reference consultation with a psychiatrist. ACOEM states 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 non-psychological 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, are referred to a specialist after symptoms continue for more than six to eight weeks. The practitioner should use his or her best professional judgment in determining the type of specialist. Issues regarding work stress and person-job fit may be handled effectively with talk therapy through a psychologist or other mental health professional. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy. Records provided indicate that the patient suffered from some depressive symptomatology; however, it was ill defined. She was given a trial of Effexor XR, which had what was described

as a modest response. Although the patient described feeling better, she refused a dose increase and refused a trial of another medication, indicating that she did not wish to be on medications. As such, this request is not medically necessary.