

Case Number:	CM14-0176206		
Date Assigned:	10/29/2014	Date of Injury:	10/01/2009
Decision Date:	12/05/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/24/2014

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 & Neurlogy, Addition Medicine, has a subspecialty in Geriatrics 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 253 pages of medical and administrative records. The injured worker is a 59 year old male whose date of injury is 10/01/2009. Diagnoses are major depressive disorder moderate to severe, PTSD, cognitive disorder NOS, and pain disorder associated with both psychological factors and a general medical condition. Medical diagnoses include dyslipidemia, hypertension, GERD, irritable bowel syndrome. He holds a [REDACTED] and was employed as a painter for [REDACTED], painting buildings and abating graffiti. He is status post closed head injury after being rear-ended in a four car collision, striking his head on the back of a metal partition in the van. He denied losing consciousness. He was taken to the ER but was not hospitalized, his brain MRI was normal. He developed dizziness, word finding difficulty, anxiety, and symptoms of PTSD, with subsequent depression around 11/2009. He experiences constant low back pain radiating up to his shoulders and neck, down to the hips and through the legs, with numbness and tingling. He has ringing in his ears with episodes of nausea, dizziness, and vertigo. In his AME of 07/20/2010 the patient reported that his flashbacks ceased around 05/2010 and nightmares decreased from nightly to weekly in early 2010. On 07/10/2010 he experienced an anxiety attack manifested by severe chest pain, nausea, dizziness, and "feeling clammy". He had previously undergone a cardiac evaluation which was negative. He was seen by [REDACTED] for neurologic consultation (date unknown) and placed on Topamax for headache prophylaxis. The patient had been on Zoloft, Trazodone, Wellbutrin, and Ativan since at least 05/2010. He has difficulty with daily activities due to marked cognitive impairment and confusion. There is reference to a supplemental AME by [REDACTED] in 2011 however that was not provided for review. A 12/02/2013 PR2 by [REDACTED] indicated that the patient's Beck Depression=35 and Beck Anxiety=34, both in the severe range of

depression and anxiety. He continued to display exaggerated startle, phobic avoidance, objective agitation, anger, anxiety, impaired concentration/memory, confusion, anhedonia, and other symptoms of depression. A PR2 of 03/31/14 shows continuing anxiety with periodic panic attacks, emotionally lability, tearfulness and irritability. Beck Depression and Beck Anxiety Inventories continue to indicate severe depression and anxiety. There were no new findings. He had been in psychotherapy for a year and a half until 04/01/14, when treatment was denied. A letter dated 05/15/2014 from his therapist, [REDACTED] indicated that the patient had developed more effective coping skills, reduced his moodiness, and increased his level of adaptive functioning. On 08/26/14 a psychiatric progress report from [REDACTED] noted that the patient was stable on Wellbutrin SR, Buspar, Ativan, and Neurontin. He had episodic anxiety and social withdrawal, with mild dysphoria. A psychiatric progress report of 09/11/14 showed that the patient was stable overall on current medications of Wellbutrin SR, Buspar, Ativan, and Neurontin. He had episodic anxiety and mild dysphoria.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medication mangement (8) 1 x 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 Guidelines-Treatment in Workers' Compensation, Pain Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Stress related conditions, Office visits

Decision rationale: This patient suffers from major depressive disorder, PTSD, and cognitive disorder. He is prescribed multiple medications and psychiatric progress reports indicate that he is overall stable. His clinical condition warrants the request for medication management however given the fact that conditions are fluid his needs cannot be anticipated 52 weeks out. It would be reasonable to request a limited number of medication management visits, over a limited time frame, e.g. three visits etc.. As such this request is noncertified at this time.MTUS does not address medication management visits.ODG office visits are 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.

Beck depression inventory 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 Guidelines-Treatment in Workers' Compensation, Mental Illness & Stress Procedure Summary

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 & Stress, Depression Screening

Decision rationale: The patient is being treated for major depressive disorder, PTSD, and cognitive disorder, and is being followed up in medication management sessions. The use of a screening tool such as the Beck Depression Inventory is recommended by ODG and would in fact be helpful in following this patient's progress and in assessing the efficacy of his medications. Presumably, it would be performed within the context of the requested medication management visits of every six weeks for 52 weeks. This would not be considered to be a standalone procedure. As such this request is noncertified.MTUS does not reference the Beck Depression Inventory.ODG: Recommended. In December 2002, the U.S. Preventive Services Task Force (USPSTF) updated its 1996 position on this topic, so that it now recommends screening adults for depression to assure accurate diagnosis, effective treatment, and follow-up, as a result of new, quality evidence. The new evidence shows that screening improves the accurate identification of depressed patients in primary care settings and that treatment of depressed adults identified in primary care settings decreases clinical morbidity. (USPSTF, 2002) As a result, the Occupational Mental Health Committee and the Council on Scientific Affairs has recommended that the American College of Occupational and Environmental Medicine (ACOEM) endorse the USPSTF report and take the position that a depression-screening program is an effective and inexpensive way to identify some of the most emotionally distressed employees. (ACOEM, 2002) In addition, one meta-analysis concluded that, compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up. (Pig none, 2002) Routine screening for depression in primary care, as recommended by organizations in the U.S. and Canada, has not been proven to be beneficial, and may even be harmful, according to a new review. About 100 people have to be screened for 1 person to receive treatment for depression. In the meantime, physicians should educate their patients about depression. General screening of anyone who comes into a primary care practice might not be high yield enough, but in certain subgroups, such as older patients, it may make sense to screen. (Thombs, 2011) See also Major depressive disorder(MDD).

Beck anxiety inventory 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 <http://www.medscape.com/viewarticle/749528>

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Assessment of anxiety in older adults: a systematic review of commonly used measures. Therrien Z, Hunsley J. Aging Ment Health 2012;16(1):1-16.

Decision rationale: The patient is being treated for major depressive disorder, PTSD, and cognitive disorder, and is being followed up in medication management sessions. The psychometric properties of the Beck Anxiety Inventory would in fact be helpful in following this patient's anxiety symptomatology and aid in assessing the efficacy of his medications. Presumably, however it would be performed within the context of his requested medication management visits. This would not be considered to be a standalone procedure. As such this request is noncertified. Neither MTUS nor ODG reference the Beck Anxiety Inventory, as such a literature search was conducted and a peer reviewed article was used in this decision.