

<b>Case Number:</b>	CM14-0184300		
<b>Date Assigned:</b>	11/10/2014	<b>Date of Injury:</b>	08/06/2008
<b>Decision Date:</b>	12/15/2014	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2014

### 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, has a subspecialty in Neurology and Addiction Medicine 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 104 pages of medical and administrative records. The injured worker is a 45 year old female whose date of injury is 08/06/2008. She experienced lower right extremity orthopedic symptoms while employed as a forklift operator. She underwent right knee surgery (apparently with poor result), physical therapy, and conservative and pain management treatments. A psychiatric AME of 08/25/2014 by [REDACTED] indicated that the patient developed psychiatric symptoms with worsening depression and anxiety in 2008 due to decreased level of functioning related to her industrial injury. This is apparently her 3rd psychiatric evaluation. The patient reported that her right lower extremity symptoms have worsened and she has undergone an additional right knee surgery. She has gained 35 lbs. due to inability to be active, and has sleep disturbance due to pain and worrying. She described a pessimistic view of her future as physical activities aggravate her orthopedic/neurologic conditions. She complains of depression, anxiety, insomnia, ambivalence, trepidation, withdrawal, reduced self-esteem, emotional lability, hopelessness, anhedonia, reduced motivation, ruminations, worthlessness, and helplessness. She had a brief trial of three psychotherapy sessions in 11/2010 which reported to be minimally beneficial for her depressive symptoms. In this AME she was given the diagnosis of major depressive disorder recurrent, and was deemed to be at psychiatric maximum medical improvement. She was on Cymbalta which was recommended to be continued, Wellbutrin was recommended as well. Twice per month supportive psychotherapy was also recommended for at least 8 months for her depression due to chronic pain. In bold print [REDACTED] stated that "if psychiatric treatment recommendations are not followed, the psychiatric conditions could possibly eventually worsen, perhaps requiring a reassessment of the case due to the worsening of this diagnosed psychiatric symptoms." Affect was flat, speech circumstantial, she had moderate difficulty in social and occupational function,

and occasional panic attacks. The AME documented that 90% of the patient's major depressive disorder was due to her industrial injury, and 10% was related to personal life issues. 09/23/14 a physician progress report shows that the patient continues to suffer from chronic pain with sleep difficulty. She was administered a PHQ9 depression inventory on which she scored a 10, indicating moderate depression. She denied suicidal ideation. On 10/21/14 the patient scored 11 on the PHQ9 again and remained on Cymbalta and Wellbutrin. She had not begun psychotherapy. On 11/10/2014 the patient was seen for reevaluation of the right knee, left shoulder, low back pain, and depression at the [REDACTED]. She had attended one PT appointment and had a flare up of low back pain that lasted several weeks. She reported that medications are well tolerated and are helpful: Percocet, Oxycontin, amitriptyline, Cymbalta, and Duexis. She rated pain as 10/10 without medications, 5/10 with medications. She was administered a PHQ9 depression inventory on which she scored 11, indicating moderate depression. She was started on Wellbutrin at her last appointment for depression per AME of 08/25/2014 recommendation, but stopped taking it as she did not like how it made her feel. At the time of this appointment she was scheduled to start psychotherapy "soon". On 10/24/2014 this same request was modified to certify psychotherapy two times per week for two weeks.

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

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

**Psychotherapy 1 time a week for 8 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23.

**Decision rationale:** The patient suffers from major depressive disorder and chronic pain related to her industrial injury. She is on antidepressants and a fair number of pain medications. In monthly follow up visits she consistently scores in the moderately depressed range on the PHQ9 scale. Per AME of 8/25/2014, supportive psychotherapy was recommended for at least 8 months to prevent worsening of the patient's symptoms. MTUS recommends behavioral intervention to develop coping skills for the pain, which may aid with the patient's depression as well. There is a certification in place for a total of four psychotherapy sessions over two weeks from 10/24/2014 but records do not reflect use of these sessions to date. Until such time as that occurs, with evidence of objective functional improvement to justify certification of additional psychotherapy services, this request is noncertified. MTUS 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. See also Multi-disciplinary pain programs. ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: 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).  
Therefore, this request is not medically necessary.