

Case Number:	CM14-0033163		
Date Assigned:	04/02/2014	Date of Injury:	04/01/2010
Decision Date:	05/28/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	12/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Psychiatry, and is licensed to practice in New York. 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 Physician 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 patient is a 58-year-old man. He reported anxiety and stress, depression, agitation, difficulty with sleep and headaches in context of being in a hostile work environment. On 4/15/2013 he suffered a stroke with resultant right sided hemisensory loss, hemiparasthesia and partial hemiparesis. Note of 11/4/13 reports that he is less motivated and was experiencing anxiety related to his medical condition and it's potential deleterious effect on his future employment. He was noted to have a depressed mood, to be withdrawn, tearful, with low self esteem, tearfulness, paranoia with auditory hallucinations, and having suicidal ideation deemed to be at "severe risk." His medications at that time were Prozac, Latuda, Zyprexa, Risperdal and Xanax. Final Determination Letter for IMR Case Number [REDACTED] He had been in psychotherapy on and off since 2008 for treatment of work related stress. Over the 5 months from 6/2013 to 11/2013 he had seen a psychiatrist 4 times, had 12 group therapy sessions and 14 individual therapy sessions. He is diagnosed with post left hemispheric stroke, post-stroke depression, post-stroke headache, sleep maintenance insomnia secondary to emotional distress and with associated daytime impairment and diabetes mellitus.

IMR ISSUES, DECISIONS AND RATIONALES

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

INDIVIDUAL PSYCHOTHERAPY, 1 TIME A WEEK FOR 20 WEEKS: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PSYCHOLOGICAL TREATMENT Page(s): 23, 101-102. Decision based on Non-MTUS

Citation OFFICIAL DISABILITY GUIDELINES (ODG), COGNITIVE BEHAVIORAL THERAPY (CBT) GUIDELINES FOR CHRONIC PAIN.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405, Chronic Pain Treatment Guidelines PSYCHOLOGICAL TREATMENT Page(s): 101. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SECTION MENTAL ILLNESS AND STRESS, OFFICE VISITS.

Decision rationale: It is suggested that in ongoing psychotherapy the goal would be to improve one's outlook, make peace with past experiences and identify further steps one could take towards treatment and recovery. ACOEM Stress related conditions chapter states that the "frequency of follow up visits may be determined by the severity of symptoms whether the patient was referred for further testing and/or psychotherapy and whether the patient is missing work." MTUS Chronic pain guidelines note that psychological treatment is "recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. " According to the ODG Mental Illness and Stress chapter office visits are "recommended as determined to be medically necessary ... 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 ... require close monitoring ... As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established." Although not totally "cured" the employee has apparently "improved" somewhat from a combination of medication management and psychotherapy and given the "severe risk" for suicide it would be prudent to continue treatment as is and not suddenly withdraw it. Individual psychotherapy 1 time a week for 20 weeks is medically necessary and should be certified.