

<b>Case Number:</b>	CM14-0043692		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	11/27/2001
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	03/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/10/2014

### 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, Addiction Medicine has a subspecialty in Geriatric Psychiatry and is licensed to practice in California and Texas. 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 injured worker is a 50 year old female whose psychiatric diagnoses are adjustment disorder with mixed anxiety and depressed mood, and depressive disorder not elsewhere classified. Her date of injury is 11/27/2001. She was employed as a program manager when she developed some problems with her upper extremities, apparently related to repetitive stress, then in 05/05 developed back problems due to lifting equipment. Her job involved primarily organizing seminars and was essentially multi-tasking, with some travelling. She underwent a lumbar fusion in 2009. She received physical therapy and chiropractic treatment, as well as cognitive behavioral therapy in 2013 for pain and anxiety. Her PR2 of 01/22/14 shows the patient to be suffering from chronic cervical spine pain radiating to her arms, and chronic bilateral arm and mid back pain, as well as depression. She was in mild distress, anxious, and depressed. She showed no pain behaviors. On 02/11/14 she was again in mild distress, anxious and depressed, with no pain behaviors. A PR2 of 04/11/14 shows her to have no change in her orthopedic symptoms. The patient reported suicidal ideation without plan, ongoing severe symptoms of depression, anxiety, insomnia, and is frightened by her loneliness. She apparently has a history of extensive psychiatric treatment but lost access as well as she was being overmedicated. Medications included Ativan, Celebrex, Lidoderm patch, Lunesta, Lyrica, Norco, Prozac, and Levothyroxine. QME 11/13/13 noted that in the past year she experienced significant emotional distress effecting her depression, appetite and sleep, and that when she eats she experiences nausea, vomiting, and diarrhea. She attested to sleeping poorly. I note that she sleeps 8 hours (11pm-7am) with reported midsleep awakening due to pain and depression. She felt sadness, insomnia, anxiety, moodiness, irritability, and occasional suicidal ideations. Prior to the Prozac she had been on Cymbalta. In 2013 she saw a psychologist for 6 sessions but the patient claimed

that there was some inappropriate behavior on the part of the psychologist, and she felt manipulated or seduced, feeling that she was unable to say no to his advances (between May-October 2013). Her depression and anxiety were exacerbated and she felt that she was no longer able to relax, as with Xanax there were too many side effects. Her psychological testing was postponed due to her extreme anxiety and inability to concentrate because of her high level of stress and inability to focus on statements. Cognitive functions were within normal limits and she was able to pay attention to the examiner's questions. Her diagnosis at the time of the QME was major depression, chronic.

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

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

**Consult with Psychiatrist:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations Chapter 7, page(s) 127-146.

**Decision rationale:** Per CA-MTUS Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. (Main-BMJ, 2002) (Colorado, 2002) (Gatchel, 1995) (Gatchel, 1999) (Gatchel, 2004) (Gatchel, 2005) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. (Gatchel, 1999). Per ACOEM practice guidelines, the practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. When a physician is responsible for performing an isolated assessment of an examinee's health or disability for an employer, business or insurer, a limited examinee-physician relationship should be considered to exist. A referral may be for: Consultation: To aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. The patient has not undergone any formal psychiatric evaluation. She has been treated with a myriad of

psychotropic medications in what appears to be a somewhat disorganized fashion. Therefore, given her subjective complaints of over-medication as well as a lack of a clear cut treatment plan towards the amelioration of her depression the request for consult with psychiatrist is medically necessary and appropriate.