

Case Number:	CM14-0071576		
Date Assigned:	07/16/2014	Date of Injury:	01/04/2006
Decision Date:	09/11/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/17/2014

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 65 year old female whose date of injury is 01/04/2006. Her primary diagnosis is major depressive disorder single episode, moderate. There is an initial psychological evaluation report dated 04/29/2014. The patient worked as a machine operator, then being transferred to cleaning small electronic parts in 2002-2003. She worked in a small room with limited ventilation where she was exposed to chemicals and was engaged in heavy lifting. She began to experience episodes of dizziness, headaches and nausea. She reported this to HR and was referred to an industrial medical clinic where she was told that this was likely due to chemical exposure. OSHA investigated, the kerosene barrel was removed, and they required her to wear protective gear and a "heavy mask", which resulted in skin outbreaks due to the rubber around her head, and she continued to experience the aforementioned symptoms. She developed pain in the neck, shoulders, and back which increased to severe spasms making it difficult to work (right greater than left), however she continued to work despite the pain. She became unable to perform activities of daily living due to increased reliance on her right upper extremity which too became difficult. She was then unable to engage in previous enjoyable activities. She began to feel depressed, anxious, irritable, and had disturbed sleep due to pain, causing daytime fatigue. Due to concern about job security she was hesitant to report her injuries to her employer. At some point she was referred to an industrial clinic. Pain medications were given and they were somewhat helpful but her emotional distress increased. She was given work accommodations but felt subjected to mistreatment by a lead person and other employees. On 01/06/06 she experienced a severe exacerbation burning in her entire back with neck spasms and was given a leave of absence. She received pain management. She was being treated with Cymbalta and Ambien for sleep, and reported a precipitous decline in

psychological functioning, not wanting to leave her house, and losing interest in her ADL's and personal hygiene. She underwent cervical spine fusion, right rotator cuff surgery, and gall bladder surgery due to gall stones. Her functioning declined she was diagnosed with fibromyalgia and arthritis in 2011, and developed bilateral knee pain with burning in her feet. She was treated for these nonindustrially. In 2012 she began a course of counseling and psychotropic medication consultations, which she found helpful for her emotional symptoms and pain, but these were discontinued after about one year due to insurance issues. At some point she discontinued all of her medications, believing that they were no longer helping, and began to experience severe body aching and an increase in psychiatric symptoms. She was told at an ER that she was experiencing withdrawals. She was able to detox from Norco, Vicodin, and Fentanyl at a day treatment program. In 2013 her orthopedic pain became difficult to tolerate and her depression worsened. She became hopeless and had suicidal thoughts without plan or intent, and the relationship with her boyfriend ended. In late 2013-early 2014 she was given Dilaudid, with relief. In 03/2014 she underwent surgery for sinusitis (nonindustrial). She has a past history of psychotherapy and medication management in 2005 for job stress. She continues the medication management, and reported that the therapy lasted one year. She reported a history of alcohol abuse beginning in her 20's which she stopped on her own in 2010, and cocaine abuse almost daily between ages 30-35, which she also discontinued on her own. Current depressive symptoms include depressed mood daily all day, weekly episodes of passive suicidal ideation, sleep difficulties due to pain, irritability, social withdrawal, episodes of tearfulness several times per week, diminished self-confidence and libido, concentration and memory difficulties, appetite disturbance, weight fluctuations, and feelings of hopelessness. Her Beck Inventories were severe for depression and severe for anxiety, Epworth Sleepiness Scale indicated an abnormal degree of daytime sleepiness which the patient felt was associated with her orthopedic pain and the sedating effects of pain medications. It was recommended that the patient receive a course of cognitive behavioral psychotherapy for approximately 8 weeks focusing on coping resources towards stress and emotional distress reduction, and management of musculoskeletal discomfort. Other recommendations included psychotropic medication management with a psychiatrist, rather than by her pain management specialist as was being done currently.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychotherapy 10 sessions: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment Page(s): 102. Decision based on Non-MTUS Citation Official Disability Guidelines: Behavioral Therapy Guidelines.

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

Decision rationale: Per CA-MTUS, behavioral interventions are 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). The patient suffers not only from major depressive disorder but pain due to her injuries. She had a brief course of psychotherapy in 2012 which was discontinued due to insurance nonpayment, which she indicated was helpful. There were no records provided to show what the nature of that improvement was. Her psychological evaluation above demonstrates quantitatively a severe level of depression and anxiety. Therefore the request is medically necessary.

Psychotropic medication consultations: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment Page(s): 102. Decision based on Non-MTUS Citation Official Disability Guidelines: Behavioral Therapy Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ACOEM), 2nd Edition, (2004) Independent Medical Examinations & Consultations, Chapter 7, page(s) 127-146.

Decision rationale: Per ACOEM, 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. It is currently unknown what, if any, psychotropic medication the patient is being prescribed. In addition, neither the orthopedic specialist nor the pain management specialist has requested consultation with a psychiatrist. Therefore the request is not medically necessary.