

<b>Case Number:</b>	CM14-0088053		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	09/27/1999
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	05/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2014

### 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 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 67-year-old female whose date of injury is 09/27/1999. She was working as a senior secretary. Her primary diagnosis is major depressive disorder, single episode. Medically she has a history of high blood pressure, GERD, hypercholesterolemia, and irritable bowel symptoms. She was pulling out 150 files for a survey, as she pulled the last set out from the bottom drawer she felt immediate pain in her back, neck, and both shoulders. The patient retired in 2001; in 2002, she began psychotherapy with [REDACTED] and psychotropic medication management with [REDACTED] then [REDACTED]. She was considered permanent and stationary in 2005. She underwent shoulder surgery in 11/04, back surgery in 06/07, another shoulder surgery in 02/08, and another back surgery in 2011. Relative to her injury and subsequent surgeries she developed depression, anxiety, and episodic crying. There was an AME of 11/15/13 by [REDACTED]. She was permanent and stationary but was receiving psychotherapy with [REDACTED], as it was felt that her stability was tenuous. She had been prescribed Zoloft by her primary care physician. In 2012, the patient was attending [REDACTED] and [REDACTED], finding those meetings helpful and supportive for the gambling problems, which had started in 1968. She gambled around weekly, worsening when she retired in 2001 being off of work. She also had a history with excessive spending. She filed for bankruptcy around 2011 due to gambling. In 2012-she felt depressed due to the lack of control over her gambling, which led to marital problems. Per patient report, her gambling also had adverse effects upon her husband's health. She went to couples therapy for marital issues. On re-evaluation in 04/13, the patient continued seeing [REDACTED] every other week and was on Zoloft. [REDACTED] diagnosed her with depressive disorder NOS, pain associated with psychological factors and general medical condition, with worsening depression and anxiety, and gambling disorder. She attended weekly [REDACTED] and [REDACTED] meetings, which enabled her to curtail her

gambling and overspending behaviors. Medications included Zantac, Prilosec, Zestril, HCTZ, Zanaflex, Norco, Tramadol, Prozac, and Xanax. ██████████ felt that she should have psychotherapy up to two times per month, psychiatric medications, and consultations every two months. PR-2 of 2/28/14 subjectively stated she is better because she did not cry very much; objectively she was prescribed Effexor and weaned off of Zoloft. In a PR-2 of 03/31/14, the patient reported stomach problems and high blood pressure (BP) when she got the news that her brother had passed, "it was very rough". Her right leg got better but the left leg started to bother her. Objective findings were increased tearfulness. In ██████████' 04/21/14 treatment authorization request, he indicated that the patient was not on psychotropic medications. He summarized that on 01/28/10 she had been in weekly individual psychotherapy, and monthly psychotropic medication consultations with a psychiatrist. In 2013, she had 21 psychotherapy sessions. Her Beck Depression Inventories were mild for depression and moderate for anxiety. The Minnesota Multiphasic Personality Inventory (MMPI-2) showed a moderate level of depression and unhappiness. The patient was anxious, depressed, irritable, and at times angry. She was considered to be permanent and stationary in 2013. She had difficulty with concentration and memory. ██████████ summarized the patient's psychotherapy sessions from 01/13-08/13. The patient reported issues such as feeling better, having more energy, feeling depressed and emotional, feeling too sleepy to drive, expressing relief that her physical therapy had been approved, found it depressing that her nephew was diagnosed with tumors all over his body and a close friend was on life support but she was strong, and she felt depressed regarding her need to use pain medication. There were no further, more current records for review.

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

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

**Weekly psychotherapy treatment for 20 weeks QTY: 20.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress, Psychotherapy.

**Decision rationale:** The patient has received 21 psychotherapy sessions in 2013. She has been in psychotherapy since 2002. All of these subjective and objective descriptions are rather vague and it is difficult to determine whether or not there has been any real improvement, except for that which she has received since attending ██████████ and ██████████, which she herself attested to as being helpful. In fact, since attending these 12 step meetings she managed to curtail her gambling and overspending. The patient appears to be learning coping skills in these 12 step meetings and has made gains in that modality. Community based systems such as the 12 step programs provide an emotionally supportive and nurturing environment wherein one can learn coping behaviors to avoid relapse back into addictive behavior, which in this patient's case would aid in her depressive episodes as they appear to be highly tied into her gambling and overspending behaviors. It is well known that there are subgroups within the main meetings that provide further support, which the patient would be able to utilize, e.g. women's groups. This

modality would be highly recommended for this patient, especially given the fact that her depressive disorder has been diagnosed as mild at best. In addition, she has received well over the ODG recommended guidelines, even had there been evidence of objective functional improvement. Therefore, this request is not medically necessary. 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. 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).As such, the request for weekly psychotherapy treatment is not medically necessary.

**Individual psychotherapy; once weekly times 20 sessions QTY: 20.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress, Psychotherapy.

**Decision rationale:** The Official Disability Guidelines (ODG) recommends psychotherapy, even if there had been evidence of objective functional improvement. Therefore, this request is not medically necessary. 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. 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).As such, the request for individual psychotherapy is not medically necessary.

**Psychotropic medication management; once monthly times 6 sessions QTY: 6.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress, Office Visits.

**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, Office visits.

**Decision rationale:** The patient does not appear to be on any psychotropic medications according to records provided for review. Therefore, this request is not medically necessary. CA-MTUS does not reference psychotropic medication management. Per the Official Disability Guidelines (ODG), office visits: 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. As such, this request is not medically necessary.