

Case Number:	CM14-0093311		
Date Assigned:	07/25/2014	Date of Injury:	02/14/2014
Decision Date:	09/09/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/19/2014

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. 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 159 pages of medical and administrative records. The injured worker is a 57 year old female whose date of injury is 02/14/2014. Her diagnosis is major depressive disorder single episode. The patient was working as a staff nurse in the emergency room at [REDACTED] beginning in 1990. She was promoted after one year to supervising clinical nurse (over 30+ employees). Around 1993 her own supervisor became [REDACTED], who over the ensuing years is alleged to have created a hostile and stressful work environment. [REDACTED] was said to have repeatedly harassed the patient, making berating, antagonistic, negative, derogatory, and intrusive remarks to her on a regular basis, e.g. questioning her purchase of a townhouse with her added recommendation of "you live alone, why don't you move into a motel", as well as commenting on her decision to return to school to study for a master's degree. She noted that [REDACTED] frequently made African-American racial jokes as well. When asked why she did not report this behavior, the patient stated that she thought it would get better, and felt that HR always finds it to be the employee's fault. In 2010 she injured her knee and was off work for around 6 months. She returned to work on modified then unrestricted duties. She developed osteoarthritis and was followed by an orthopedist, having to take some days off due to knee pain. On 07/02/13 the patient took a complaint from another RN who also felt harassed and retaliated against, but his own supervisor as well as [REDACTED] refused to listen to him. [REDACTED] found out about this complaint and apparently became furious, feeling that the patient should have told her about the complaint even though it was against regulations as she ([REDACTED]) was named in the complaint. The patient reported that [REDACTED] told her that she had to retire, and if she needed her medical coverage "there's always Obamacare, you can sit in the waiting room like the other patients". In January 2014 the patient

requested a transfer to [REDACTED]. On 02/03/14 she received a negative performance evaluation from [REDACTED]. Around 02/10/14, after a staff nurse had to be floated to another shift, the patient said that [REDACTED] accused her and another employee of talking "shift" in front of other employees. The patient reported that [REDACTED] berated her, called her names and would not stop. The patient felt the onset of a panic attack and excused herself from the room, after which [REDACTED] took her back into the room. The patient, with [REDACTED] agreement, went home as she felt too upset to work. The following day [REDACTED] asked for a doctor's note (she had not said that she needed or was going to see a physician) and was docked 10 hours for absence without pay. On 02/14/14 the patient filed a grievance with her union. She went to [REDACTED] and upon arrival became overwhelmed and had a panic attack. She was given Remeron and Ativan, and taken off work. She was then prescribed Lexapro and Klonopin, and referred to an intensive training program (group) for coping skills, which she attended twice weekly for four weeks. She obtained no benefit from this group. She was then referred to a work stress clinic and attended two group sessions, also providing no benefit. She was evaluated on 04/10/14 by a [REDACTED], at [REDACTED], but it is unclear what the outcome of that was. She apparently was not referred for physical examination for the somatic complaints she was experiencing. In this psychological evaluation the patient noted that she felt overwhelmingly depressed, humiliated, demoralized, confused, and lost, and that over the years the stress etc. have worn her down. She felt that they were trying to take her career away. She was preoccupied with recounting her experiences with [REDACTED]. She was crying almost constantly and could not sleep, with or without medications, due to anxiety. She worries about her health and complained of muscle aches and tension headaches, GI distress, and diarrhea. She has gained weight due to stress eating. Concentration is poor, as is motivation. Within this evaluation is a review of the grievance filed on 09/19/13 to the [REDACTED] concerning the creation of a hostile and dangerous work environment. It noted that [REDACTED] condoned another supervisor for blatantly making inappropriate comments, along with [REDACTED] inappropriate remarks quoted. This complaint was signed by 57 employees, with the statement that the verbal abuse needs to stop immediately. Psychological testing was done with scores as follows: Cornell Medical Index Health Questionnaire=50 (large number and array of physical symptoms), Beck Depression Inventory=33 (severe), Beck Anxiety Inventory=35 (severe). She was not found to be malingering. Diagnoses given were major depressive disorder single episode, moderate to severe, psychological factors effecting medical condition, and sleep disorder, insomnia type. There is a progress report dated 05/30/2014 showing that the patient was in outpatient psychotherapy. She continued to complain of body pain, headache, GI distress, and aggravation of her diabetes and hypertension. Psychologically she was "doing fairly", trying to adjust to being off work, addressing fears and anxiety with her inability to continue working. She continued to report overwhelming depression, tearfulness, decreased activities, preoccupation of loss and frustration regarding her inability to be vindicated and return to work without further harassment. She was motivated to learn and implement cognitive and behavioral interventions and showed affective and mood improvements.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Psychotherapy , twice monthly thru 7/30/14 (4 sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines.

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, Cognitive therapy for depression.

Decision rationale: The patient presented with a long history of work related stress, culminating in symptoms of depression along with complaints of pain and insomnia. Her psychological testing scores indicate that she is in the severe range for depression and anxiety. She had been certified for five psychotherapy sessions twice monthly through 06/30/14, however it is unknown from records provided how many of those were utilized. In addition, the progress note of 05/30/14 does not show functional objective improvement in symptoms, only vague and brief description of the patient's report of improvement. She had not yet received a psychiatric evaluation to determine if she would benefit from medication therapy, which would potentially work in tandem with psychotherapy towards a better overall result for this patient. As noted below in ODG, the "gold standard" of treatment for major depressive disorder remains medications plus psychotherapy. As such, until the psychiatric evaluation is completed, this request is noncertified. CA-MTUS refers to psychotherapy related to pain, therefore ODG was utilized. Cognitive therapy for depression is recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). (Paykel, 2006) (Bockting, 2006) (DeRubeis, 1999) (Goldapple, 2004) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. (Gloaguen, 1998) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. (Corey-Lisle, 2004) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. (Pampallona, 2004) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. (Royal Australian, 2003) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. Maintenance cognitive-behavioral therapy (CBT) to prevent recurrent depression is most effective in patients at highest risk for relapse, defined as those with 5 or more previous depressive episodes. For individuals at more moderate risk for recurrence (fewer than 5 prior episodes), structured patient psychoeducation may be equally effective. High-risk patients in particular may benefit from specific elements of maintenance CBT by reducing cognitive vulnerability factors for recurrent depression, such as ruminating, negative attributions and memories, and dysfunctional beliefs, or by maintaining positive emotions when experiencing stress. (Stangier, 2013) See also Bibliotherapy. Psychotherapy visits are generally separate from physical therapy visits.

Psychiatric evaluation/ treatment: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-101.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

Decision rationale: The patient presented with a long history of work related stress, culminating in symptoms of depression along with complaints of pain and insomnia. Her psychological testing scores indicate that she is in the severe range for depression and anxiety. She has not yet received a psychiatric evaluation and does not appear to be on any antidepressants, anxiolytics, etc. This request is considered medically necessary and is therefore certified. CA-MTUS does not address psychiatric evaluations. Per ACOEM, specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities. Some mental illnesses are chronic conditions, so establishing a good working relationship with the patient may facilitate a referral or the return-to-work process. Treating specific psychiatric diagnoses are described in other practice guidelines and texts. It is recognized that primary care physicians and other nonpsychological specialists commonly deal with and try to treat psychiatric conditions. It is recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than six to eight weeks. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy.