

<b>Case Number:</b>	CM14-0173073		
<b>Date Assigned:</b>	12/12/2014	<b>Date of Injury:</b>	09/28/2001
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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 348 pages of medical and administrative records. The injured worker is a 63 year old male whose date of injury is 09/28/2001. His primary diagnosis is depressive psychosis moderate. Orthopedic diagnoses are cervical and lumbar strain, and bilateral shoulder tendinitis. He was involved in a motor vehicle accident in which he sustained neck, shoulder, back, upper extremity, and lower extremity pain. Around 2003 he developed headaches, and by mid-2004 right knee pain. He returned to work then was placed on disability, followed by attending a vocational rehab program. Treatments included medication, physical therapy, acupuncture, and epidural injections. He continued to suffer from constant neck pain accompanied by headaches with tingling in his fingers and nocturnal numbness eased by medications, and bilateral back pain with numbness down both legs, and experienced urinary problems. Orthopedic surgery progress notes from 04/03/14, 5/16/14, 07/15/14, and 09/08/14 reported tenderness and spasm of the cervical and lumbar spine with restricted range of motion. On 10/01/13 a psychiatric AME reported symptoms of depression, anxiety, and nervousness. The patient reported that his pain had been worsening since 2008-2009. He is depressed daily which is worsening, having difficulty making decisions, is forgetful, has difficulty with memory, and has had thoughts of harming himself but never attempted. He is easily angered and is irritable, yelling at others. Sleep onset is one to two hours with mid sleep awakening. He has erectile dysfunction. He was diagnosed with chronic pain associated with both psychological factors and general medical condition and depressive disorder not otherwise specified with anxiety. Antidepressant medication was recommended with monitoring every two to three months or as necessary once stable, as well as eight cognitive behavioral therapy sessions. On 06/18/14 he was evaluated psychologically by [REDACTED] PhD who reported the patient's

diagnoses as major depressive disorder single episode moderate, PTSD chronic, erectile disorder, insomnia related to PTSD and chronic pain, and stress related physiological response affecting headaches. He had depressed affect, memory difficulties, preoccupied with physical limitations and pain, anxious/sad/dysphoric mood, and nervousness. Subjectively he reported symptoms of depression, anxiety, and PTSD. CBT with hypnotherapy and a psychiatric evaluation were recommended. A neurologic consultation of 08/22/14 recommended a MRI of the brain due to his ongoing headaches. A progress note of 09/11/14 by Dr. [REDACTED] reported that the patient had some improved ability to use relaxation exercises to manage symptoms. Medications included Tramadol and Diclofenac. On 10/07/14 one psychiatric office visit was certified to determine appropriate medication management, with further visits/treatments being noncertified pending the outcome of this consultation.

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

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

#### **Psychiatric office visits x 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405.

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

**Decision rationale:** The patient suffers from symptoms of depression and anxiety. This was first reported in the psychiatric AME of 10/01/13, at which time medications were recommended. He is receiving psychological treatment, with some improvement reported. On 10/07/14 he was certified for one psychiatric office visit. Clearly this patient would benefit from having this service to evaluate him for medication management. There is no evidence that this has yet occurred. Until such time as the initial psychiatry visit takes place with, further visits cannot go forward. This request is therefore not medically necessary. 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.