

Case Number:	CM14-0191677		
Date Assigned:	11/25/2014	Date of Injury:	01/27/2012
Decision Date:	02/09/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/17/2014

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 Psychiatrist (MD 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 78 pages of medical and administrative records. The injured worker is a 61 year old female whose date of injury is 01/27/2012. The primary diagnosis is major depressive disorder single episode moderate, orthopedic diagnoses include lumbar sprain, lumbar disc tear, and resolved cervical strain. On 04/06/14 [REDACTED] performed a medical legal re-evaluation. Based on psychological testing he diagnosed the patient with pre-existing PTSD from another injury, aggravated by this injury. He also noted anxiety and depression which exacerbated gastrointestinal distress and headaches, and that she required immediate resumption of psychotropic medication augmentation. In an initial psychological evaluation report of 10/21/14 the patient related that in the course of her employment as an [REDACTED] teacher she backwards fell down several stairs, hitting her head at the bottom and losing consciousness. When she awoke the principal instructed her not to move while he called her husband. As she waited, she said that students swore and spat on her, and an aid assigned to stay with her taunted her. She was subsequently transported to the emergency room and treated. She underwent epidural injections and returned to work for a short period. She developed increased depressed mood and was constantly in pain. She currently experiences chronic orthopedic pain, and headaches triggered by stress. She has been seeing a psychiatrist ([REDACTED]) monthly since 2012, and has been on Effexor 150mg, Geodon 40mg, and Seroquel 25mg. She was also on Tramadol and Percocet. She complained of anxiety, tearfulness, hopelessness, irritability, social withdrawal, sleep disturbance. She related staying in her pajamas all day around five days a week, and break through anxiety. However she did describe an active social life, going to lunch weekly with her son with the occasional movie, lunching with friends, going to church, spending time with her daughter a couple of times per week, talking with neighbors and friends. She

occasionally has a nightmare of one of the students attacking her (she was previously attacked by a student in 1988).

IMR ISSUES, DECISIONS AND RATIONALES

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

CBT x 12 weekly sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive Behavioral Therapy.

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

Decision rationale: The patient suffers from major depressive disorder single episode, and she is on medication management. She indicated ongoing chronic pain. She has been seeing a psychiatrist monthly since 2012. She described symptoms of depression including social withdrawal but in direct opposition described an active social life with friends, neighbors, her children, and church. This does not have the appearance of a patient who is socially withdrawn and staying in her pajamas all day 5 days per week. Given this picture it is difficult to truly assess the necessity for CBT, as her current activities can be interpreted as coping skills to deal with her current situation. While MTUS does recommend behavioral interventions, the first step would be an initial trial of 3-4 psychotherapy visits over two weeks, followed by assessment for objective functional improvement before further sessions are authorized. There is no evidence that this has been attempted. As such this request is noncertified. 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).

Psycho-pharmacological follow-up x 7: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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 is on a regimen of multiple medications, including Effexor, Geodon, Seroquel, Tramadol, and Percocet. While close follow up is indicated to maintain a high

quality of care, if the patient is stable on her medication regimen it would not appear to be necessary to be seen monthly unless her condition changes. Preauthorizing seven monthly visits in advance is not reasonable as one cannot anticipate the needs of the individual patient and on what schedule she may need to be seen. It is reasonable to allow for one psychopharmacology follow up at this time. This request is therefore noncertified. CA-MTUS does not reference psychopharmacologic follow up. ODG was used in the formulation of this decision. Office visits are 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.