

Case Number:	CM14-0198654		
Date Assigned:	12/09/2014	Date of Injury:	04/30/1998
Decision Date:	01/23/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/25/2014

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), has a subspecialty in Neurology, Addiction Medicine, & 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 72 pages of medical and administrative records. The injured worker is a 65 year old male whose date of injury is 04/30/98. He is permanent and stationary. The primary diagnosis is major depressive disorder, moderate. On 10/20/14 a request for treatment authorization noted that the patient received individual psychotherapy on an as needed basis. He had two sessions in 2013, and had five psychotropic medication consultations in 2014 (last in 09/14). He has been on Cymbalta and Ativan since at least 2011 as mentioned in this report. He underwent a sleep study and received a CPAP machine, but found it "horrible" and stopped using it. He was on Ambien. In 05/14 he reported sleepwalking and in 06/14 was switched to Restoril. His Beck Inventories suggested moderate levels of depression and anxiety, and Wahler Physical Symptoms Inventory suggested a high degree of preoccupation with somatic symptoms and physical functioning. The patient was able to sleep around six hours per night with meds. He was irritable, angry, tearful, and socially withdrawn. Self-esteem and libido were low, and he had difficulty concentrating and remembering. His medications include Cymbalta, Ativan, Restoril, and Viagra. Goals of the requested psychotherapy were described.

IMR ISSUES, DECISIONS AND RATIONALES

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

CBT (as needed basis - 45 minute sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Biofeedback. 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 ODG Mental Illness & Stress Cognitive therapy for depression ODG Psychotherapy Guidelines

Decision rationale: The patient suffers from major depressive disorder, moderate, with ongoing symptoms. The "gold standard" for treating major depressive disorder is psychotherapy and medications. He had two sessions in 2013 which he found helpful. The goals described for the requested psychotherapy are reasonable in that the patient may benefit from learning skills such as increasing social interactions, self-assessment and his outlook for the future, integration of his past experiences and current situation, and sleep hygiene education (obviating the need/request for sleep medications). Studies have shown that a 4-6 session trial should be adequate to show symptom improvement. However, this request does not specify a number of sessions over a specific time period. CA-MTUS references CBT related to chronic pain, not depression. 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). It also fared well in a meta-analysis comparing 78 clinical trials from 1977 - 1996. In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. 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. The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. (Warren, 2005) Delivering cognitive behavioral therapy (CBT) by telephone is as effective as delivering it face-to-face in the short term and telephone therapy is safe and has a higher patient retention rate. The attrition rate from psychotherapy can exceed 50% due to time constraints, lack of available and accessible services, transportation problems, and cost. Significantly fewer participants receiving telephone CBT discontinued their therapy than did those receiving face-to-face CBT. Both treatment groups showed significant improvement in depression, and there were no significant treatment differences when measured at post treatment between telephone and face-to-face CBT. However, face-to-face CBT was significantly superior to telephone CBT during the follow-up period. The RCT used 18 sessions of either telephone CBT or face-to-face CBT. (Mohr, 2012) 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 psych education 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. Studies show that a 4 to 6 session trial should be sufficient to provide evidence of symptom improvement, but functioning and quality of life indices do not change as markedly within a short duration of psychotherapy as do symptom-based outcome measures. Subclinical depression: Psychotherapy may be effective in treating subclinical depression and may prevent progression to major depressive disorder (MDD), according to a meta-analysis. There has been recent controversy regarding the efficacy of psychotherapy in treating subclinical depression, and antidepressants and benzodiazepines are no better than placebo for treating this condition. The most common form of psychotherapy used was cognitive-behavioral therapy. Results showed that undergoing psychotherapy significantly reduced the incidence of MDD at the 6-month follow-up, with a relative risk (RR) of 0.61 vs the control groups. ODG Psychotherapy Guidelines indicate up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made. Therefore the request is not medically necessary.

Cymbalta: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment 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, Duloxetine (Cymbalta)

Decision rationale: The patient suffers from major depressive disorder. He has been treated with Cymbalta 60mg #30. Although this request simply states "Cymbalta", it is fair to assume that it means Cymbalta 60mg #30. Given the patient's ongoing depressive symptoms it would be medically unwise to disallow him an antidepressant and risk destabilizing him. Therefore this request is certified for Cymbalta 60mg #30. CA-MTUS 2009 does not reference Cymbalta as it relates to major depressive disorder. Duloxetine (Cymbalta), an inhibitor of serotonin and norepinephrine reuptake, has been approved for the treatment of major depressive disorder. Duloxetine has been shown to be effective in the treatment of first and subsequent episodes of major depressive disorder, and regardless of duration of the current depressive episode. One meta-analysis examining potential gender differences in the efficacy of duloxetine concluded that efficacy did not differ significantly in male and female patients. Cymbalta, an SNRI from Lilly, has been approved by the FDA for both the treatment of depression and the management of pain associated with diabetic peripheral neuropathy. Cymbalta targets two chemicals, serotonin and norepinephrine, that are believed to play a role in how the brain and body affect mood and pain. Note: On October 17, 2005, Eli Lilly and the U.S. Food and Drug Administration (FDA) notified healthcare professionals of revision to the Precautions/Hepatotoxicity section of the prescribing information for Cymbalta (duloxetine hydrochloride), indicated for treatment of major depressive disorder and diabetic peripheral neuropathic pain. Post marketing reports of hepatic injury (including hepatitis and cholestasis jaundice) suggest that patients with preexisting liver disease who take duloxetine may have an increased risk for further liver damage. The new labeling extends the precaution against using

Cymbalta in patients with substantial alcohol use to include those patients with chronic liver disease. It is recommended that Cymbalta not be administered to patients with any hepatic insufficiency. Therefore the request is medically necessary

Ativan: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The patient's anxiety was not well defined in documentation provided for review. Ativan has been prescribed since at least 2011 per records provided, well beyond MTUS recommendations against long term use beyond 4 weeks. Reviews of 09/17/14 and 10/01/14 show that Ativan must be weaned by the treating physician, and by this time this should have occurred. Given that information, this request is denied. Per CA-MTUS 2009, Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Therefore the request is not medically necessary.

Restoril: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Insomnia treatment

Decision rationale: He was started on Restoril, a benzodiazepine, in 06/14. Prior to being on Restoril he had been on Ambien (a non-benzodiazepine). He had experienced sleepwalking. He had a sleep study and was issued a CPAP machine however he discontinued its use. The use of Restoril has extended beyond MTUS recommendations of short term use of benzodiazepines of four weeks. It is unknown if he has been tried on melatonin receptor agonists (e.g. Rozerem), or if a sedating antidepressant (e.g. Trazodone, mirtazapine) has ever been tried. In addition, no evidence of sleep hygiene education was reported. Reviews on 09/17/14 and 10/01/14 indicate that Restoril must be weaned by the treating physician. By this time this should have occurred. Per CA-MTUS 2009, Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle

relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Per ODG Mental Illness & Stress, Insomnia Treatment recommend that treatment be based on the etiology, with the medications recommended below. See Insomnia.

Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. See the Pain Chapter for detailed recommendations and references. Pharmacologic Treatment: There are four main categories of pharmacologic treatment: (1) Benzodiazepines; (2) Non-benzodiazepines; (3) Melatonin receptor agonists; & (4) Sedating antihistamines (primarily over-the-counter medications). (1) Benzodiazepines: These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events (daytime drowsiness, anterograde amnesia, next-day sedation, impaired cognition, impaired psychomotor function, and rebound insomnia). These drugs have been associated with sleep-related activities such as sleep driving, cooking and eating food, and making phone calls (all while asleep). Particular concern is noted for patients at risk for abuse or addiction. Withdrawal occurs with abrupt discontinuation or large decreases in dose. Decrease slowly and monitor for withdrawal symptoms. Benzodiazepines are similar in efficacy to benzodiazepine-receptor agonists; however, the less desirable side-effect profile limits their use as a first-line agent, particularly for long-term use. (2) Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists): First-line medications for insomnia. Although direct comparisons between benzodiazepines and the non-benzodiazepine sedative-hypnotics have not been studied, it appears that the non-benzodiazepines have similar efficacy to the benzodiazepines with fewer side effects and short duration of action. Zolpidem [Ambien (generic available), Ambien CR, Edluar, and Intermezzo] is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults. FDA has also approved sublingual Zolpidem FDA approved Zolpidem tartrate sublingual tablets (Intermezzo) for use as needed for insomnia characterized by middle-of-the-night waking followed by difficulty returning to sleep. (FDA, 2011) Due to adverse effects, FDA now requires lower doses for Zolpidem. The dose of Zolpidem for women should be lowered from 10 mg to 5 mg for IR products and from 12.5 mg to 6.25 mg for ER products. The ER product is still more risky than IR. Zaleplon (Sonata) reduces sleep latency. Because of its short half-life (one hour), may be re-administered upon nocturnal waking provided it is administered at least 4 hours before wake time. This medication has a rapid onset of action. Short-term use (7-10 days) is indicated with a controlled trial showing effectiveness for up to 5 weeks. Eszopicolone (Lunesta) has demonstrated reduced sleep latency and sleep maintenance. The only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. Sedating Antidepressants (e.g., Amitriptyline, Trazodone, and Mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. Trazodone is one of the most commonly prescribed agents for

insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Improvements in sleep onset may be offset by negative next-day effects such as ease of awakening. Tolerance may develop and rebound insomnia has been found after discontinuation. (3) Melatonin-receptor agonist: Ramelteon (Rozerem) is a selective melatonin agonist (MT1 and MT2) indicated for difficulty with sleep onset; is nonscheduled (has been shown to have no abuse potential). One systematic review concluded that there is evidence to support the short-term and long-term use of Ramelteon to decrease sleep latency; however, total sleep time has not been improved. (4) Sedating antihistamines (primarily over-the-counter medications): Sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine [Benadryl, OTC in U.S.], promethazine [Phenergan, prescription in U.S., OTC in other countries]). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. This RCT determined that diphenhydramine has been shown to build tolerance against its sedation effectiveness very quickly, with placebo-like results after a third day of use. Due to adverse effects, the U.S. National Committee for Quality Assurance (NCQA) has included diphenhydramine in the HEDIS (Healthcare Effectiveness Data and Information) recommended list of high-risk medications to avoid in the elderly. (NCQA, 2012) Non-pharmacologic treatment: Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. Treatments that are thought to probably be efficacious include sleep restriction, biofeedback, and multifaceted cognitive behavioral therapy. Suggestions for improved sleep hygiene: (a) Wake at the same time every day; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping. In terms of first-line therapy, for acute insomnia lasting less than 6 months, medication is probably the best treatment approach, but for chronic insomnia, a combined approach with CBT might give the best of both worlds; however, after a few weeks, the recommendation is to discontinue the medication and continue with CBT. Therefore the request is not medically necessary.(1) Benzodiazepines: These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events (daytime drowsiness, anterograde amnesia, next-day sedation, impaired cognition, impaired psychomotor function, and rebound insomnia). These drugs have been associated with sleep-related activities such as sleep driving, cooking and eating food, and making phone calls (all while asleep). Particular concern is noted for patients at risk for abuse or addiction. Withdrawal occurs with abrupt discontinuation or large decreases in dose. Decrease slowly and monitor for withdrawal symptoms. Benzodiazepines are similar in efficacy to benzodiazepine-receptor agonists; however, the less desirable side-effect profile limits their use as a first-line agent, particularly for long-term use.(2) Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists): First-line medications for insomnia. Although direct comparisons between benzodiazepines and the non-benzodiazepine sedative-hypnotics have not been studied, it appears that the non-benzodiazepines have similar efficacy to the benzodiazepines with fewer side effects and short duration of action. Zolpidem [Ambien (generic available), Ambien CR, Edluar, Intermezzo] is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults. FDA has also approved sublingual zolpidem (Edluar). (FDA, 2009) FDA approved zolpidem tartrate sublingual tablets (Intermezzo) for use

as needed for insomnia characterized by middle-of-the-night waking followed by difficulty returning to sleep. (FDA, 2011) Due to adverse effects, FDA now requires lower doses for zolpidem. The dose of zolpidem for women should be lowered from 10 mg to 5 mg for IR products and from 12.5 mg to 6.25 mg for ER products. (FDA, 2013) The ER product is still more risky than IR. See the Pain Chapter. Zaleplon (Sonata) reduces sleep latency. Because of its short half-life (one hour), may be readministered upon nocturnal waking provided it is administered at least 4 hours before wake time. This medication has a rapid onset of action. Short-term use (7-10 days) is indicated with a controlled trial showing effectiveness for up to 5 weeks. Eszopicolone (Lunesta) has demonstrated reduced sleep latency and sleep maintenance. The only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. Sedating Antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Improvements in sleep onset may be offset by negative next-day effects such as ease of awakening. Tolerance may develop and rebound insomnia has been found after discontinuation. See also Sentra PM.(3) Melatonin-receptor agonist: Ramelteon (Rozerem) is a selective melatonin agonist (MT1 and MT2) indicated for difficulty with sleep onset; is nonscheduled (has been shown to have no abuse potential). One systematic review concluded that there is evidence to support the short-term and long-term use of ramelteon to decrease sleep latency; however, total sleep time has not been improved.(4) Sedating antihistamines (primarily over-the-counter medications): Sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine [Benadryl, OTC in U.S.], promethazine [Phenergan, prescription in U.S., OTC in other countries]). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. This RCT determined that diphenhydramine has been shown to build tolerance against its sedation effectiveness very quickly, with placebo-like results after a third day of use. (Richardson, 2002) Due to adverse effects, the U.S. National Committee for Quality Assurance (NCQA) has included diphenhydramine in the HEDIS (Healthcare Effectiveness Data and Information) recommended list of high-risk medications to avoid in the elderly. (NCQA, 2012)Non-pharmacologic treatment: Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. Treatments that are thought to probably be efficacious include sleep restriction, biofeedback, and multifaceted cognitive behavioral therapy. Suggestions for improved sleep hygiene: (a) Wake at the same time everyday; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping. In terms of first-line therapy, for acute insomnia lasting less than 6 months, medication is probably the best treatment approach, but for chronic insomnia, a combined approach with CBT might give the best of both worlds; however, after a few weeks, the recommendation is to discontinue the medication and continue with CBT.

Viagra: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American Urological Association Guidelines on the Treatment of Erectile Dysfunction 2006

Decision rationale: Symptoms are not described, there does not appear to be any work up, and documentation provided is inadequate to show the necessity for Viagra. This request is therefore noncertified. CA-MTUS 2009, ACOEM, and ODG were all searched for references to Viagra, and erectile dysfunction. The American Urological Association Guidelines for the Management of Erectile Dysfunction 2006 were used. Phosphodiesterase-5 inhibitors (sildenafil, tadalafil, vardenafil) are recommended as first line agents for ED unless contraindicated. An initial sexual history should be conducted in addition to medical and psychosocial histories, followed by a physical exam. Management begins with the identification of organic and psychosexual issues, and identification of any comorbidity. Work up and treatment of coexisting medical conditions, as well as assessment for side effects of other agents prescribed to the patient which may affect erectile function, should be taken into consideration when and if treatment is decided upon. Therefore the request is not medically necessary.

Additional psychotropic medication consultations (x6): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 multiple medications which do require monitoring for efficacy, side effects, and potential changes. However, the number of psychotropic medication consultations cannot be predicted, they are based upon the individual needs of the patient, taking into account level of stability, other medications prescribed etc. Although this injured worker clearly requires this service as he continues to show depressive symptoms, the request for six is not reasonable. I would recommend allowing for one additional psychotropic medication consultation. CA-MTUS 2009 does not reference psychotropic medication consultation. ODG Mental Illness & Stress, 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. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through

self-care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payers for possible evaluation, however, payers should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits; however the value of patient/doctor interventions has not been questioned. Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. Therefore the request is not medically necessary.