

<b>Case Number:</b>	CM14-0205472		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	12/08/2011
<b>Decision Date:</b>	02/11/2015	<b>UR Denial Date:</b>	11/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 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 293 pages of medical and administrative records. The injured worker is a 41 year old male whose date of injury is 12/08/2011. His diagnoses are depressive disorder NOS, PTSD, and sexual dysfunction NOS. He was on a lift that was struck by another crane, the lift hit the ceiling causing the patient to sustain a blunt head trauma with loss of consciousness, nasal fracture, cervical spine disc bulges with radiculopathy in both upper extremities, insomnia, dental injury, anxiety, and PTSD. He was treated with neck injections, surgical repairs of the nasal fractures, pain medications, and CBT. UR of 11/11/14 denied 12 additional psychiatric treatments for lack of evidence to support improvement. A psychotherapy report of 09/12/14 noted week 12 of 12 CBT sessions. He had ongoing pain, depressed mood 5 days per week, loss of interest, crying episodes, nightmares, fatigue, poor concentration/memory, feelings of worthlessness, hopelessness about the future, lack of interest, and intrusive thoughts. He denied suicidal ideation. He was able to sleep 8 hours with medication. He scored in the 99th percentile for depression, 95th for anxiety. No functional improvement in ADL's was noted. His symptoms and depression/anxiety ratings were essentially unchanged over the course of these 12 psychotherapy sessions since 03/07/14. Medications were zolpidem 5mg at night, alprazolam 0.5mg daily as needed for anxiety, buspirone 10mg daily, and venlafaxine ER 75mg daily. At the time of the psychotherapy note of 05/23/14, his medications were Cymbalta, buspirone 20mg per day per day, and estazolam sleep. The rationale for the change from Cymbalta to venlafaxine and the decrease of buspirone from 20mg to 10mg per day was not provided. There is a PR2 of 10/30/14 from [REDACTED], orthopedic surgeon. The patient was working with restrictions. He came in for follow up for persistent pain in the neck rated at 6/10, frequent with occasional headaches, occasional numbness into both hands with weakness. He takes Motrin which helps

his pain down to 4/10, allowing him to continue to work with restrictions. No further psychotherapy notes were provided.

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

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

#### **12 Additional Psychiatric Treatments: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment Page(s): 102.

**Decision rationale:** The patient suffers from depressive disorder NOS, PTSD, and sexual dysfunction NOS. He had received 12 CBT sessions, without evidence of functional improvement. His rating scales and symptoms were essentially unchanged over the course of those sessions. His antidepressant was changed from Cymbalta to venlafaxine, with no rationale provided. The dose does not appear to have been changed either in a patient whose depressive symptomatology remained quite high. His buspirone (antianxiety medication) was decreased from 20mg to 10mg, again with no rationale provided, again, in a patient whose anxiety level rating remained high. Per CA-MTUS 2009, CBT and self-regulatory treatments incorporated into pain treatment has been found to have a positive short term effect on pain interference and long term effect on return to work. ODG guidelines state, if progress is being made, up to 13-20 visits over 7-20 weeks of individual sessions. There was no evidence of objective functional improvement documented. This request is therefore noncertified.