

Case Number:	CM14-0206315		
Date Assigned:	12/31/2014	Date of Injury:	03/08/2013
Decision Date:	02/11/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/09/2014

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 1274 pages of medical and administrative records. The injured worker is a 43 year old male whose date of injury is 03/08/2013. He fell 10 feet from a roof, landing on cement on the left side of his body. Two of his discs were injured. Treatments included PT, home exercise, medications, and cortisone injection to the left elbow. He returned to work, again at height and he fell again. He caught himself and hung suspended in the air. He developed chronic panic attacks and anxiety, with elevated blood pressure, profuse sweating, shortness of breath, constant worrying, and reliving the accident. An office visit with [REDACTED] (pain management) on 10/15/14 shows medications of gabapentin, Nabumetone-relafen, Prednisone, Orphenadrine-norflex ER, and Metoprolol. Diagnoses given were psychogenic pain NEC, unspecified major depression recurrent, and generalized anxiety disorder. He suffered from increased social isolation and avoidance, decreased self-care, limited functional ability, difficulties engaging independently in the world, and struggling with accepting his chronic condition. All of those factors were resulting in delayed recovery. An office visit note of 10/21/14 indicated that he had a recent panic attack, and was not taking medication. Mood was depressed with generalized anxiety related to his industrial injury and pain syndrome. In his most recent psychotherapy session of 10/28/14 he reported feeling a panic attack coming on as well as having somatic symptoms. A psychiatric evaluation was recommended. An office visit of 11/21/14 noted that he had been on venlafaxine 37.5mg BID, he reported more stable moods and felt less depressed. In an appeal letter of 11/25/14 the patient complained of pain in the neck, low back with radiation into the left buttock and left sided radicular pain, and left elbow. He reported anxiety and depression related to chronic pain, mood appeared anxious and depressed. He had continued distress regarding his finances, and about chronic pain preventing him from working. He had been unable to schedule the authorized CBT as he did not have a

working phone. On pain profile he showed high anxiety and elevated depression scores, and more physical problems and pain than the average pain patient. He experienced his current state of anxiety as intense, unremitting, and overwhelming. His profile showed an extremely high level of somatization and obsessive compulsive symptoms were in the clinical range. He is unable to take benzodiazepines as he is an alcoholic, 3 medication management sessions were requested with a psychiatrist was requested for his ongoing anxiety and depression, the first being a consult followed by two follow ups. On 12/04/14 this request was modified to one session with a psychiatrist. No further records were provided beyond this date.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 sessions of psychiatric medication management with a psychiatrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-101. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC Mental Illness and Stress Procedure Summary

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 suffers from panic attacks and anxiety. It appears that he had not been evaluated psychiatrically since his date of injury, and that his psychological symptoms have been followed by pain management and his therapist. He was reported to have been on venlafaxine in 11/14, the status of that is currently unclear. His psychological testing shows scores in the high levels of anxiety, elevated depression, high level of somatization, and obsessive compulsive symptoms in the clinical range. It was noted that due to being an alcoholic he is unable to take benzodiazepines, but the medical rationale behind this is unclear. On 12/04/14 he received certification for one psychiatric session. There were no records provided to show that this had occurred. He is undoubtedly in need of a psychiatric evaluation for a number of reasons, not least of which would be to determine his diagnosis, followed by the appropriate pharmacological treatment. This IW would in fact benefit from further psychiatric treatments if he is placed on psychotropic medication, however this cannot be certified until the initial consultation is performed. In addition, the number of visits cannot be predetermined as the patient's needs cannot be anticipated at this time. As such this request is not medically necessary.