

<b>Case Number:</b>	CM15-0146947		
<b>Date Assigned:</b>	08/07/2015	<b>Date of Injury:</b>	10/05/2012
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	07/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Psychologist

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 49 year old female, who sustained an industrial injury on 10-5-2012. The mechanism of injury was cumulative trauma. The injured worker was diagnosed as having major depressive disorder, cluster B personality disorder features and sleep apnea. There is no record of a recent diagnostic study. Treatment to date has included cognitive behavior therapy, psycho-education, therapy and medication management. In a progress note dated 6-25-2015, the injured worker reports improved mood, recent panic attacks, depression, anhedonia, irritability, anger and suicidal ideation. Physical examination showed she was cooperative with mild agitation. The treating physician is requesting 6 medication management sessions, 6 group psycho-education for anxiety and 18 group psycho-education insomnia sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**6 medication management sessions:** 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): 405, 398b.

**Decision rationale:** The ACOEM guidelines state that the frequency of follow visits may be determined by the severity of symptoms, whether the patient was referred for further testing and/or psychotherapy, and whether the patient is missing work. These results allow the physician and patient to reassess all aspects of the stress model (symptoms, demands, coping mechanisms, and other resources) and to reinforce the patient's supports and positive coping mechanisms. Generally, patients with stress-related complaints can be followed by a mid-level practitioner every few days for counseling about coping mechanisms, medication use, activity modification, and other concerns. These interactions may be conducted either on site or by telephone to avoid interfering with modified for full duty work if the patient has returned to work. Followed by a physician can occur when a change in duty status is anticipated (modified, increased, or forward duty) at least once a week if the patient is missing work. Furthermore, regarding psychiatry referral, the ACOEM states that 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 the patient may facilitate a referral for 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 non-psychological specialists commonly deal with and try to treat psychiatric conditions. It is also recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, are referred to a specialist after symptoms continue for more than 6 to 8 weeks. The practitioner should use his or her best professional judgment in determining the type of specialist. Issues regarding work stress and person-job fit may be handled effectively with talk therapy through a psychologist or other mental health professional. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy. In this case, the request for 6 sessions was modified by utilization review to allow for 2 sessions. The request for 6 sessions is excessive in length as it would be the equivalent of 6 months of treatment assuming that the sessions are held once per month and longer if held more infrequently. The patient is prescribed the medications Effexor XR 225 mg and Trazodone 100 mg. Abilify and Adderall were also mentioned in a June 29, 2015 QME but it is not clear if these are being utilized currently. Once a patient is stabilized on psychotropic medications the need to follow up on a monthly basis is often excessive if they can be followed in a step down manner once stabilized. Because the need for medication management has been established but medical necessity for 6 months' worth of treatment or more is not due to excessive quantity and duration, the utilization review decision is upheld.

**6 group psychoeducation for anxiety:** 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): 389.

**Decision rationale:** The ACOEM guidelines state that patient education is a cornerstone of effective treatment. Patients may find it therapeutic to understand the mechanism and natural history of the stress reaction and that it is a normal occurrence when their resources are overwhelmed. Education also provides the framework to encourage the patient to enhance his or her coping skills, both acutely and in a preventative manner by regularly using stress management techniques. Physicians, ancillary providers, support groups, and patient-appropriate literature are all educational resources. A request was made for 6 sessions of group psychoeducational treatment for anxiety. The request was not approved by utilization review which provided the following as its rationale: "earlier in this review, the request for 6 cognitive behavioral therapy sessions is recommended certified. However, additional amounts of psychoeducation specifically for anxiety does not appear and in addition to cognitive behavioral therapy already recommended certified." At the time of the request for 6 psychoeducational sessions for anxiety was made the patient was approved for 6 sessions of cognitive behavioral therapy. At this juncture the request for both treatment modalities appears to be excessive and not medically necessary. According to a treatment progress note from June 29, 2015, the patient "finished psychoeducation for depression and found it very helpful and completed." There's no mention made of how many sessions this treatment included. Is not clear how psychoeducational group for insomnia would differ from the depression group she just completed. It is not clear how many total prior sessions of psychoeducation she has received for all symptoms. Under the treatment plan mentioned in this note the request it says "please authorize 6 sessions course for insomnia and 18 sessions course for anxiety. This is the reverse of what is requested here creating a lack of clarity. Because there is no clear statement in the medical records regarding how much treatment the patient has had in total included group CBT and group psychoeducational it could not be clearly determined whether the request was consistent with MTUS and industrial guidelines for chronic pain treatment for if the request is excessive. Given that she is currently participating in group CBT and has prior group psychoeducational treatment unknown quantity of both it is a reasonable assumption that the request exceeds ODG recommendations for CBT treatment 13-20 session max for most diagnoses. For these reasons the medical necessity of this request is not established and the UR determination is upheld.

**18 group psychoeducation insomnia sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ODG Cognitive behavioral therapy (CBT).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 389.

**Decision rationale:** The ACOEM guidelines state that patient education is a cornerstone of effective treatment. Patients may find it therapeutic to understand the mechanism and natural history of the stress reaction and that it is a normal occurrence when their resources are overwhelmed. Education also provides the framework to encourage the patient to enhance his or her coping skills, both acutely and in a preventative manner by regularly using stress management techniques. Physicians, ancillary providers, support groups, and patient-appropriate literature are all educational resources. A request was made for 18 sessions of psychoeducational group treatment for insomnia, the request with non-certified by utilization review provided the following for its rationale: "Earlier in this review a request for 6 cognitive

behavioral therapy sessions is recommended certified. At this time, an additional 18 sessions specifically for insomnia did not appear to be medically necessary. As a result, additional sessions are not recommended until the completion of the original 6 requested and documented functional improvement." According to a treatment progress note from June 29, 2015, the patient "finished psychoeducation for depression and found it very helpful and completed." There's no mention made of how many sessions this treatment included. Is not clear how psychoeducational group for insomnia would differ from the depression group she just completed. Under the treatment plan mentioned in this note the request it says "please authorize 6 sessions course for insomnia and 18 sessions course for anxiety. This is the reverse of what is requested here creating a lack of clarity. There is no clear statement in the medical records regarding how much treatment the patient has had and thus it could not be determined whether the request was consistent with MTUS and industrial guidelines for chronic pain treatment for if the request is excessive. An individual psychotherapy progress note from August 7, 2015 was reviewed, there was no indication of how many sessions the patient has received to date is no. In addition, the note does not describe functional improvement as a direct result of prior treatment sessions. Continued significant psychiatric symptoms including depression and anxiety were mentioned. Because there is no clear statement in the medical records regarding how much treatment the patient has had in total included group CBT and group psychoeducational, it could not be clearly determined whether these requests are consistent with MTUS and industrial guidelines or if the request is excessive. Given that she is currently participating in group CBT and has prior group psychoeducational treatment unknown quantity of both, it is a reasonable assumption that the request exceeds ODG recommendations for CBT treatment (13-20 session max for most diagnoses). For these reasons, the medical necessity of this request is not established and the UR determination is upheld.