

Case Number:	CM15-0087002		
Date Assigned:	05/11/2015	Date of Injury:	07/13/2012
Decision Date:	06/19/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/06/2015

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 65-year-old male, who sustained an industrial injury on 07/13/2012. According to an orthopedic evaluation dated 04/13/2015, the injured worker was seen in follow-up regarding injuries sustained to the head, cervical, thoracic and lumbar spine and bilateral shoulders resulting in emotional distress. Pain was rated 7 on a scale of 1-10. A psychiatrist who recommended psychotropic medications but were denied evaluated him. He was also recommended to see a clinical psychologist. Another provider also recommended epidural injections. Diagnoses included chronic neck pain with underlying moderate degenerative disc disease C5-C6 and stenosis at C4, C5, C6 and C7, right and left shoulder painful motion, chronic mid back pain with diffuse degenerative disc disease, chronic low back pain with 3 millimeter disc protrusion L2-3 and L3-4 and 3-4 millimeter disc protrusion at L5-S1, complaints of headaches and complaints of depression, anxiety and difficulty sleeping. Treatment plan included follow up in three months, corticosteroid injections into the cervical spine, laboratory analysis, work restrictions, Gabapentin, Remeron, 10 additional psychiatric visits and a consultation with clinical psychologist. Currently under review is the request for psychiatric follow up visits, 10 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychiatric follow up visits, 10 visits: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 387-414.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398-B and 405.

Decision rationale: ACOEM chapter 15 page 398 B, Referral. 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. Chapter 15, page 405. 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, a mid-level practitioner can follow patients with stress-related complaints 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. Decision: a request was made for 10 psychiatric follow-up visits; the request was non-certified by utilization review with the following rationale provided: "there is no documentation of the level of improvement based on initial consultation as well as no indication as to proposed treatment plan." This IMR will address a request to overturn that decision. Concerning the patient's psychiatric/psychological functioning, and according to a primary treatment physician progress note from March 25, 2015, the patient is reporting depression, headache, and anxiety as well as difficulty sleeping, has been prescribed the medication Cymbalta to address the symptoms, and has not noticed any significant improvement since starting the medication. There is a notation from April 13, 2015 as follows: "the patient states he was evaluated by [REDACTED], the psychiatrist, and was recommended for psychotherapeutic medications. However, these medications were subsequently denied. It is noted that the medications being requested were gabapentin and Remeron as well as 10 additional psychiatric visits. It was also recommended [REDACTED] who is a clinical psychologist evaluate this patient. However, the patient states that he has yet to receive any authorizations or appointments for that provider." A copy of the December 20, 2014 psychiatric evaluation by [REDACTED] [REDACTED], MD was found in included medical records. The detailed comprehensive evaluation

provides a diagnosis of major depression and pain disorder and provides a complete overview of the patient's psychiatric condition. 10 sessions were apparently requested at that time and have not been approved, as best as could be determined the patient has not received any psychiatric care for the current related industrial injury. Although the request for 10 sessions as an initial course of psychological treatment is somewhat more excessive than what should be authorized for an initial course of treatment. There are no specific rules for psychiatric follow-up frequency/duration is there is for general cognitive behavioral psychotherapy. Despite the fact that this request appears to be slightly excessive in terms of session quantity for an initial treatment (ODG for psychological treatment initial treatment trial is 4 to 6 sessions and MTUS is 3-4 visits), the request for psychiatric treatment does appear to be medically appropriate and indicated for this patient with the only disputing area being that of the session quantity of 10. Because the patient has been properly identified as someone who may benefit from psychiatric treatment, and because treatment has been delayed unnecessarily the medical reasonableness and appropriateness of the request appears to be established by the provided documentation and therefore the utilization review determination is overturned and the request for 10 psychiatric treatment sessions is medically necessary.