

<b>Case Number:</b>	CM14-0161647		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	06/19/2013
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	09/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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 Psychiatry & Neurology, Addiction Medicine, 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 126 pages of medical and administrative records. The injured worker is a 43 year old male whose date of injury is 06/19/2013. During the course of his employment as a custodian at [REDACTED] he was attacked by a patient resulting in injuries to the facial bones, spinal cord, and neck, mouth, and left shoulder. He developed symptoms of anxiety and depression manifested by sadness, helplessness/hopelessness, crying episodes, less energy, irritability, weight and appetite changes, lack of sexual desire, sleep disturbance, headaches, anger, difficulty concentrating, and preoccupation with his physical limitations. Diagnoses include major depressive disorder single episode mild, generalized anxiety disorder, male hypoactive sexual desire disorder due to chronic pain, insomnia related to generalized anxiety disorder and chronic pain, stress related physiological response affecting gastrointestinal (GI) disturbances, headaches, closed head trauma, cervical myofascial sprain/strain, and lumbar myofascial sprain/strain, and post-traumatic stress disorder. His planned treatments included psychotherapy, desensitization, and psychiatric evaluation and monthly follow up. Orthopedic AME of 11/13/13 noted impairment in activities of daily living ranging from 2/5 (hearing/speaking) to 5/5 (bathing, lifting, and writing). He complained of constant neck, bilateral shoulder, and low back pain. On exam his shoulders were normal, low back showed slight loss of range of motion with normal X-rays. He had received physical therapy, injections, and medications, with minimal benefit. On 02/28/14, he received the following MRI's and results. The brain was unremarkable. The C-spine MRI revealed disc desiccation C2-C3 to C7-T1, straightening of the cervical lordosis with decreased ROM in flexion/extension (may reflect an element of myospasm), and C4-C5 broad based posterior disc herniation causing spinal canal stenosis with concurrent bilateral unvertebral joint degenerative change. Lumbar spine with

flex/ext: disc desiccation L1-L2 through L5-S1, straightening of the lumbar lordosis with decreased ROM in flexion/extension (may reflect an element of myospasm), L4-L5 diffuse disc herniation causing spinal canal stenosis and bilateral recess with concurrent facet hypertrophy, causing stenosis of the bilateral neural foramen that contact the visualized bilateral L4 exiting nerve roots. He was authorized for 12 physical therapy treatments on 05/07/14 but no progress notes were provided. Cervical and lumbar ROM was decreased. On 06/28/14, there is a doctor's first report of occupational injury, which Zoloft was prescribed and Trazodone was continued. From records provided it does not appear that the patient was able to receive these medications on an ongoing basis so the efficacy is unknown. A psychological progress report of 05/23/14 shows that the patient had made some progress towards current goals evidenced by some improvement in social functioning and was better able to manage his anxiety by utilizing coping exercises. He was prescribed Tramadol on 09/03/2014.

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

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

**Psychiatric treatment and medications (unspecified): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

**Decision rationale:** CA-MTUS does not address psychiatric treatment and medications. Per ACOEM, 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 with the patient may facilitate a referral or the return-to-work process. Treating specific psychiatric diagnoses are described in other practice guidelines and texts. It is 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 six to eight weeks. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy. There is inadequate documentation provided to support the need for psychiatric treatment and medications. The patient's current symptomatology and current prescriptions have not been determined. In addition, the request itself is vague, the medication requested is unknown, and there is no time frame given. Therefore, this request is not medically necessary.

**Physical therapy for the cervical, thoracic and lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Page(s): 98-99 of 127.

**Decision rationale:** Physical Medicine is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) The patient received certification for 12 physical therapy sessions on 05/07/14. It is unknown how many of those sessions were used to date. There are no reports of objective functional improvement in this patient. The request was vague, no number or time frame was specified. Therefore, this request is not medically necessary.