

<b>Case Number:</b>	CM14-0195148		
<b>Date Assigned:</b>	12/02/2014	<b>Date of Injury:</b>	05/17/2013
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	11/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2014

### 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, has a subspecialty in Addiction Medicine 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 340 pages of medical and administrative records. The injured worker is a 21 year old female whose date of injury is 05/17/2013 in which she suffered a closed head injury when a coworker threw an object which struck the back of her head. There was no loss of consciousness. She developed a migraine that night which progressively worsened, associated with dizziness and blurred vision. She subsequently developed depression and anxiety which worsened one to two months post injury. The primary diagnosis is depressive disorder not elsewhere classified. She also suffers from cervical strain, head injury, cognitive disorder NOS, anxiety, and depression. Treatments received include pain medication, acupuncture, chiropractic, and physical therapy. On 09/20/13 a follow up report indicated that she had extreme anxiety with psychiatric issues about problems in her workplace and feared returning to work. On 11/11/13 depression and symptoms consistent with post-traumatic stress disorder (PTSD) were noted in a neurosurgical primary treating physician's progress report (PR2). On 02/03/14 she received a psychological consultation. She ruminated and worried excessively, reported multiple symptoms of anxiety, moderate dissociative depression. AME of 09/03/14 by a psychiatrist indicated that her first documented psychiatric issues were on 09/20/13 with anxiety due to work issues. She suffered from postconcussive syndrome headaches. A neurosurgical evaluation of 10/14/13 recommended a psychiatric evaluation for possible PTSD and depression. Effexor was recommended but declined by the patient due to potential side effects. She began seeing a psychologist in 02/2014. She has some difficulty with activities of daily living (ADL's) due to anhedonia. Levels of depression, anxiety, and psychiatric difficulty were in the mild to slightly moderate range. She reported a history of intense anxiety associated with heart racing, chest discomfort, and shortness of breath occurring on an average of once per day. She was on Tramadol as needed, cyclobenzaprine as needed for muscle relaxation,

meclizine, and naproxen. She related that she avoids more medication use in general due to the risk of side effects. On 10/01/14 a PR2 reported that the patient complained of dizziness when moving eye focus and problems with memory. She was provided biofeedback to improve mental clarity. On 10/22/14 she demonstrated neck pain and stiffness, wakes up with pain, dizziness, and disorientation. She showed guarded cervical spine range of motion (ROM), thrombotic thrombocytopenic purpura (TTP) with myofascial signs, upper extremities showed decreased sensation C6-C8, and left Temporomandibular (TMJ) tenderness with normal mastication. On 11/01/14 she was in the process of being evaluated at [REDACTED] and was receiving biofeedback to improve frontal lobe function. Per UR of 11/06/14 she had received 14 psychological sessions without objective functional improvement documented.

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

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

**Psychiatric consult:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101-102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Stress and Mental Chapter

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

**Decision rationale:** The patient suffered a closed head injury with sequela of depression, anxiety, and cognitive disorder. Specific symptoms of depression and anxiety have not been reported in PR2's (e.g. subjectively and objectively), and in her AME of 09/03/14 her depression and anxiety were rated in the mild to slightly moderate range (ACOEM recommends referral for more serious conditions). She has refused antidepressants offered in the past, is not currently on psychotropic medications, and has indicated that she tries to avoid more medication due to side effects. At last report she was being evaluated at the [REDACTED] CA-MTUS does not address psychiatric evaluations. 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 recognized that primary care physicians and other nonpsychological specialists commonly deal with and try to treat psychiatric conditions. 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. Given all of these factors, this request is not medically necessary and appropriate at this time.

**Psychological treatment 10-15 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 23.

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

**Decision rationale:** As of the latest report of 11/06/14 (utilization review), the patient had already received 14 psychotherapy sessions. There was no documentation in records provided for review that objective functional improvement was gained in that symptoms were not described at the start of treatment and at any points in between or at the end. No quantifying scales were apparently administered (e.g. Beck Anxiety or Beck Depression Inventories). There was no evidence that progress was being made. In fact, the patient's AME reported her in the mild-mildly moderate range of depression, anxiety, and psychiatric issues. As such this request is not medically necessary.