

Case Number:	CM13-0016355		
Date Assigned:	11/06/2013	Date of Injury:	09/28/2007
Decision Date:	01/28/2014	UR Denial Date:	08/15/2013
Priority:	Standard	Application Received:	08/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation has a subspecialty in Pediatric Medicine and Rehabilitation and is licensed to practice in Illinois, Indiana and Texas. 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 physician 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:

The patient is a 32 year old female who reported an injury on 09/28/2007. The mechanism of injury was a psychological injury. The clinical documentation submitted or review stated the patient developed major depression, including dysphoric and anxious mood, crying spells, irritability, insomnia, fatigue and difficulties maintaining concentration and memory. The patient was diagnosed with major depressive disorder, single episode, severe without psychosis; panic disorder without agoraphobia; history of borderline and dependent personality features. The patient was treated with cognitive behavioral therapy and medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prolonged evaluation and management service before and/or after direct patient care:
Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental and Stress Section

Decision rationale: The CA MTUS, ACOEM does not address the submitted request. ODG guidelines recommended office visits as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. However, the clinical documentation submitted for review does not show a routine schedule as to the length of an evaluation, what may be covered during an evaluation or indicate the direct patient care services. As such, the request is non-certified.

Special reports such as insurance forms: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental and Stress Section.

Decision rationale: The CA MTUS and ACOEM address the submitted request. The Official Disability Guidelines (ODG) guidelines recommended office visits as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits; however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, The clinical documentation submitted for review indicates the patient was being treated for major depression, including dysphoric and anxious mood, crying spells, irritability, insomnia, fatigue and

difficulties maintaining concentration and memory. The submitted request is a decision for special forms. However, the clinical documentation does not indicate any special reports submitted. As such, the request is non-certified.