

Case Number:	CM13-0031641		
Date Assigned:	12/04/2013	Date of Injury:	07/09/2009
Decision Date:	02/18/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	10/03/2013

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 Psychiatry & Neurology, has a subspecialty in Geriatric Psychiatry, 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 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:

Records reviewed include 89 pages of administrative and medical records. The claimant is a 41 year old psychiatric nurse whose date of injury is 07/09/09. She carries the diagnosis of major depressive disorder single episode (296.2) has a history of major depression. The patient was re-evaluated in AME on 11/15/12. At that time she reported feeling more anxious than depressed, with nightmares about 4 times per week revolving around events in the inpatient unit where she worked. She has been suffering from headaches, gastrointestinal discomfort, trouble with memory, less enjoyment in activities, and self-doubt. She has hypertension which is controlled by medications. She is on Paxil 30mg QD and Ativan 2mg BID. A supplemental report by [REDACTED] 10/10/13 was reviewed, in which he describes that prior to 2009 the patient experienced a stressful work environment during which time she developed sleep disorders, stomach pain, and depressed mood. She witnessed a coworker being assaulted by a patient, and she herself was approached by a patient with a handmade weapon. She began to have nightmares and was diagnosed with hypertension. Her depression deepened and she became anxious with panic and rapid heartbeat. In November 2008 she was placed on a 2 week medical leave of absence, after which the stressful situation worsened. In March 2009 she changed to the night shift to avoid her supervisor, who she felt was treating her in a discriminatory fashion, filing a grievance that same month. In July 2009 the environment became more stressful when a male nursing assistant began making inappropriate remarks to her. She was placed on medical leave of absence in 07/09/09. Paxil and Xanax were prescribed by her [REDACTED] physician, and she was referred to the intensive outpatient program, then a work stress group. [REDACTED], a psychiatrist, prescribed Paxil and Ativan around September 2009. She was diagnosed with major depressive disorder, single, moderate, with panic symptoms and psychotherapy with

medication consultation was recommended. She was re-evaluated on several occasions over the ensuing years, and as of 03/25/13 had been seeing a staff psychologist every 2 weeks (with benefit) and [REDACTED] (staff psychiatrist) for prescribing and monitoring of Paxil and Ativan (frequency unspecified), which she found helpful. She returned to work on 03/13/13 with restrictions, working in the pediatric emergency department. She felt that was also understaffed, with inadequate provision for agitated, out of control psychiatric patients. She became anxious and apprehensive, and her sleep deteriorated, some nights sleeping 2-5 hours, others sleeping excessively. She stopped working again in June 2013 due to overwhelming stress. Her [REDACTED] internist treats her hypertension with Norvasc and prescribes Ambien for sleep. She uses Sumatriptan for headaches. [REDACTED] describes the patient as irritable and angry, with diminished self-confidence and self-esteem, and she continues to be tearful at times. Her libido is low. Her ability to concentrate has deteriorated and she has poor focus, she does not feel ready to return to work, and is less motivated to be active in her life. He feels that the purpose and goal of the Ativan is to reduce her anxiety and tension, while also contributing towards improved sleep. The Paxil, being an SSRI antidepressant, is used to reduce anxiety and prevent panic attacks while being effective in the treatment of major depression. Efficacy and dosage will be monitored by [REDACTED] via psychological testing and follow up interviews. [REDACTED] notes in this report that in 02/13 the patient reported feeling less depressed and was sleeping 7.5-8 hours per night, though she was still experiencing tearfulness. By 06/13, even though she had stopped working due to stressful conditions, she reported feeling less depressed while off work and she was sleeping well

IMR ISSUES, DECISIONS AND RATIONALES

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

Monthly psychotropic medication management (duration not specified): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG), Section Mental Illness & Str.

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

Decision rationale: According to the ODG guidelines, ongoing office visits play a critical role in the return to function of an injured worker and should be encouraged. Determination with respect to such visits is based on the patient's condition, level of stabilization, and the outcome which is to be achieved. In this case this employee was diagnosed with a major depressive episode which was treated with Paxil (SSRI), Ativan (a benzodiazepine), and Ambien for sleep. As of June 2013, the employee had stabilized to the point of being less depressed but was still not working. It appears that the employee is going to attempt a return to work yet again. It would be my consideration that the employee be afforded monthly psychotropic medication management visits for the next 6 months, during which time a solidification of the employee's condition would take place such that the employee might be able to return to gainful employment. The MTUS guidelines do not specifically reference psychotropic medication management. The ODG guidelines regarding Office Visits indicates they are recommended 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 t