

Case Number:	CM13-0031849		
Date Assigned:	12/04/2013	Date of Injury:	11/02/2007
Decision Date:	11/24/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	10/04/2013

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 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:

Injured worker is a 60 year old female with date of injury 11/02/2007. Date of the UR decision was 09/13/2013. It has been documented that the injured worker had 95 sessions of hypnotherapy from 03/10/09 to 09/10/13. She has been diagnosed with diagnosed with major depressive disorder, generalized anxiety disorder, female hypoactive sexual desire, and sleep disorder. Report dated 10/7/2013 indicated that the injured worker presented with subjective complaints of improved mood and decreased levels of depression with group psychotherapy and medication. She reported feeling sad and worried about her physical condition. She was nervous, stressed, and pressured. She reported experiencing persisting pain which interfered with her engagement in her ADL's. She felt frustrated by her levels of pain and physical condition. She reported that the pain was interfering with her sleep and that she was sleeping about three to four hours at night. She also reported memory difficulties, concentration problems, and confusion. The objective findings per that report were sad and anxious mood; apprehensive; bodily tension; poor concentration, restless. She reported persisting symptoms of anxiety and depression that require continued treatment. She has been prescribed Klonopin 0.5 mg daily for anxiety; Prilosec 20 mg for gastrointestinal upset and Sertraline 50 mg every day.

IMR ISSUES, DECISIONS AND RATIONALES

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

MEDICATION MANAGEMENT: 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 illness, Office visits Stress related conditions

Decision rationale: ODG states "Office visits: 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. " Documentation suggests that the injured worker has been diagnosed with diagnosed with major depressive disorder, generalized anxiety disorder, female hypoactive sexual desire, and sleep disorder. She has been prescribed Klonopin 0.5 mg daily for anxiety; Prilosec 20 mg for gastrointestinal upset and Sertraline 50 mg every day. The request for Medication management does not specify the number of office visits being requested, the goals of treatment or the duration of time the treated is being requested for. Thus, the request for Medication Management is not medically necessary.