

Case Number:	CM13-0037317		
Date Assigned:	12/13/2013	Date of Injury:	04/25/2011
Decision Date:	02/04/2014	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	09/30/2013

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 and Neurology, has a subspecialty in Geriatric Psychiatry and Addition 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: 191 pages of medical and administrative records. This is a 36 year old female who sustained a repetitive motion injury on 4/25/11. She has the diagnoses of major depression, single episode mild, and insomnia related to anxiety disorder not otherwise specified and chronic pain. QME report of 4/18/13 notes that the claimant experienced shooting pain in her hands while typing, but continued working with slight pain. She was ultimately seen by a company physician who told her that it was inflammation, prescribed Naproxen, and cleared her to return to work. She felt unable to do so due to pain and went to a private physician who diagnosed a strain due to repetitive use and tendonitis, and cleared her to work with restrictions. Her employer was able to accommodate to these until 06/11. In 08/11 they placed her in a position in which she did not have to perform repetitive motion tasks however she continued to experience pain. She was treated with physical therapy (no relief), acupuncture (some relief), and was prescribed Vicodin, Prednisone, and Meloxicam. EMG was normal, NCV was abnormal. Physician's first report of injury of 5/31/13 shows claimant describing herself as having sad mood, irritability, low energy, feels like crying, self critical, less interest in activities, nervous, restless, tense, fearful without cause, shaky, excess worry, sleep difficulties, gastric disturbances, and headaches. Objective findings include memory difficulties, rapid speech, sad/anxious mood, poor concentration, bodily tension. Current medications at that time included Prozac 60mg, Trazodone at HS, Vicodin BID, Prilosec, Flonase, and occasional Motrin. Progress report of 8/23/13 by [REDACTED] reports the claimant as stable but self reporting as nervous, showing excessive worry, gastric disturbance, easily fatigued, persistent pain, social withdrawal, and having sleep difficulties. Objective findings are preoccupation with physical condition, b

IMR ISSUES, DECISIONS AND RATIONALES

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

Office visit (99215): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS treatment Page(s): 40.

Decision rationale: This service was initially not authorized as the initial progress report dated 8/23/13 by [REDACTED] did not include a request for further psychological treatment. An amended report dated 8/23/13 has since been received which includes a request for office visit. The claimant continues to show subjective and objective symptoms of anxiety and depression. She is currently on Zoloft and Trazodone, which require monitoring for efficacy. Please note however that in progress notes to date there are no metrics which measure the claimant's progress, or lack thereof. It would be most helpful if scales such as the Beck Depression Inventory and Beck Anxiety Inventory would be administered such that the claimant's subjective symptoms of depression/anxiety can be documented over time during clinical psychological visits. I am authorizing the office visit requested. CAMTUS 2009 Psychological treatment: Focused on improved quality of life, development of pain coping skills, cognitive-behavioral therapy, and improving facilitation of other modalities. (a) Early stages: education. (b) Next steps: clinical psychological assessment (after 6 to 8 weeks): identification of stressors; identification of comorbid Axis I psychiatric disorders (depression, anxiety, panic and post-traumatic stress).