

<b>Case Number:</b>	CM13-0062642		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	08/23/2007
<b>Decision Date:</b>	03/21/2014	<b>UR Denial Date:</b>	11/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2013

### 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 Psychiatry and 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:

This is a 39-year-old female whose date of injury is 08/23/2007. She sustained an inhalation injury for which she underwent endoscopy, bronchoscopy, and was treated with medications. She was subsequently involved in a (MVA) motor vehicle accident. There was a concern of gastroesophageal reflux however no evidence was found. Her diagnoses are adjustment disorder with mixed anxiety and depressed mood, chronic, female hypoactive sexual desire disorder due to pain, insomnia sleep disorder due to pain, and psychological factors affecting medical conditions. 10/21/2013 Panel QME in Psychiatry, [REDACTED] the patient was treated with Celexa for anxiety after being fired from a job in 05/04. As of 2008 she no longer needed psychotherapy however she did require ongoing medication consultations. In 01/2013 he notes that Cymbalta 60mg was prescribed, and on 02/01/13 the patient reported that "I am better". She was less depressed and more hopeful. The evaluatee may now be seen on a quarterly medication basis. 01/29/2014 request for treatment authorization: reports that the patient is currently suffering from chronic persisting depressed mood, sleep disorder, tearfulness, and anxiety. Also noted was that her diagnosis was amended in December 2013 to reflect major depressive disorder, single episode, moderate. The patient remained on Cymbalta 60mg daily.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Psychotropic Medication Management and Medical approval, 1 session per month for 6 months:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines

**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, and Office Visits

**Decision rationale:** California MTUS does not specifically address psychotropic medication management and medical approval. ODG 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. 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, for example Chiropractic manipulation and Physical/Occupational therapy. Review of medical records indicate medical necessity for ongoing evaluation and management of this patient's medication treatment so as to monitor for efficacy and side effects which may occur, changes which may need to be made, as well as any potential drug-drug interactions in order to maintain stability of the patient. However sessions once per month for 6 months are beyond what is recommended per standard of practice in the community, which would be quarterly, or once per 3 months. As such this request is non-certified.