

<b>Case Number:</b>	CM14-0002294		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	01/04/2013
<b>Decision Date:</b>	06/09/2014	<b>UR Denial Date:</b>	12/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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:

The patient has submitted a claim for Depressive Psychosis, severe associated with an industrial injury date of January 4, 2013. Treatment to date has included SSRIs, diphenhydramine, psychotherapy, and biofeedback. Medical records from 2013 were reviewed and showed chronic pain related to the right lower extremity injury. Current reported symptoms include depression of mood, anxiety features, flashbacks, social withdrawal, sleep disturbance, excessive caution, irritability and post traumatic nightmares. The patient also described difficulty coping, feeling easily overwhelmed, increased and racing heart rate, irritability, restlessness, apathy, social withdrawal, moodiness, erratic sleeping and frequent early morning awakening. No suicidal ideations were reported. She often forces herself to initiate activities due to amotivation, isolation, anhedonia and apathy. She notes a change in manner from her earlier spirited and ambitious and uninhibited self. On examination, the patient's mood was constricted, depressed and anxious. She was decidedly careful and hypervigilant, yet was able to be mutual, to smile, and to use some humor. Thought content was appropriate to the topics of the interview. The patient demonstrated no gross cognitive disturbance and no difficulty with abstraction or generalization. The patient is diagnosed with major depressive disorder, anxiety, posttraumatic stress disorder, pain disorder associated with both psychological factors and a general medical condition. The patient was prescribed with Fluoxetine for the depressive features and post trauma anxiety symptoms; and diphenhydramine to aid sleep. The patient had previous individual psychotherapy sessions which afforded the patient with functional improvements such as being able to manage pain more effectively, increased level of daily activities, and increased self-care. Treatment plan includes six months of monthly medication management office visits for the treatment of posttraumatic stress disorder and depressive disorders.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **6 MONTHLY MEDICATION MANAGEMENT OFFICE VISITS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Office Visits.

**Decision rationale:** As stated on page 405 of the ACOEM Stress-related Conditions Guidelines referenced by CA MTUS, frequency of follow-up visits may be determined by the severity of symptoms, whether the patient was referred for further testing and/or psychotherapy, and whether the patient is missing work. These visits allow the physician and patient to reassess all aspects of the stress model (symptoms, demands, coping mechanisms, and other resources) and to reinforce the patient's supports and positive coping mechanisms. Generally, patients with stress-related complaints can be followed-up by a midlevel practitioner every few days for counseling about coping mechanisms, medication use, activity modifications, and other concerns. ODG Pain chapter states that the determination of clinical office visit is based on what medications the patient is taking, since some medicines such as opiates, among others, require close monitoring. In this case, the patient's clinical presentation is consistent with depression psychosis, severe for which she was prescribed with fluoxetine. The medical necessity for medication monitoring has been established, however, there is no discussion concerning the continued need for six monthly visits. Without documentation of continued medical necessity, the request for 6 monthly medication management office visits is not medically necessary.