

Case Number:	CM14-0017295		
Date Assigned:	04/14/2014	Date of Injury:	09/28/2009
Decision Date:	06/03/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	02/11/2014

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 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:

This is a 48-year-old male injured worker with date of injury 9/28/09. The injury is related to low back pain with numbness in bilateral buttock and down both legs. The treatment has included conservative care, facet injections, epidural steroid injection (ESI), and three back surgeries, including fusions. Per 3/21/14 progress report, cognitive behavioral therapy (CBT) was authorized and was to be set up on that date. Per 3/13/14 note "he is up at 4-5 am with tears due to the pain in his back and shoulders that wakes him up. He is frustrated with the med/surgical workup thus far, hoping for more clarity and more proactive interventions or imaging studies. He is not motivated for a spinal cord stimulator. In psychotherapy we addressed his automatic negative thoughts and his fears of recommended treatments while helping him maintains therapeutic alliances with his clinicians given his wanting to stop certain treatments." His psychotropic medications include Cymbalta 120mg and Trazodone which was recently titrated to 200mg, it was noted that there was a partial response to the new dose but that he felt over-sedated in the am. It was reviewed whether he would be a good candidate for some version of detoxification in the future and he agreed to discuss it his pain management physician. Objective findings included pressured speech, intense affect, depressed and frustrated mood, he admitted to intrusive thoughts of passive suicidal ideation but denied intent, he remained ruminative over his somatic complaints. Axis I diagnoses include major depressive disorder, single episode, severe; pain disorder associated with both psychological factors and a general medical condition. The date of utilization review decision was 1/13/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

TEN (10) MONTHLY PSYCHIATRIC MEETINGS FOLLOWED BY QUARTERLY MEETINGS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem blue Cross (2013). Behavioral health medical necessity criteria. Psychiatric outpatient treatment. Medication management, pg. 43.

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), Mental Illness & Stress, Office Visits.

Decision rationale: According to CA MTUS guidelines "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 by a midlevel practitioner every few days for counseling about coping mechanisms, medication use, activity modifications, and other concerns." The Official Disability Guidelines (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. The request for 10 monthly psychiatric meetings followed by quarterly meetings is not medically necessary and appropriate.