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| Case Number: | CM14-0124389 | | |
| Date Assigned: | 08/08/2014 | Date of Injury: | 10/05/2005 |
| Decision Date: | 09/17/2014 | UR Denial Date: | 07/15/2014 |
| Priority: | Standard | Application Received: | 08/06/2014 |

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 & Neurology, Addiction Medicine, has a subspecialty in Geriatric 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:

Records reviewed include 209 pages of medical and administrative records. The patient is a 47 year old male whose date of injury is 10/05/2005. His primary diagnosis is major depressive disorder, single episode moderate, anxiety-depression. He stepped off of a curb, breaking his right lower leg. He underwent rodding for the right tibia on 10/05/05, hardware removal in 2008, and nonsurgical treatments of chiropractic/physiotherapy to the wrist, lumbar area, physical therapy for the right ankle, acupuncture, and wrist/hand massage. His lumbar spine is positive for a 3.5cm central posterior disc protrusion L5-S1. In terms of psychological treatment, the patient was seeing [REDACTED]. On 03/14/14 there was improvement in anxiety, depression, self-esteem, confidence, irritability, frustration, and short temperedness. He cried 3 x per week. He continued to have difficulty with sleep, memory and concentration. Objectively he showed mildly anxious mood and underlying residual depression, and mild impairment in recent memory. He was receiving monthly psychotherapy. On 04/03/14 and 05/01/14 the patient reported ongoing depression, tearfulness, and irritability. Objectively [REDACTED] indicated that the patient had been taking Prozac 20mg, Ativan 2mg, Ambien 10mg, and Viagra 100mg "for years". The most recent record is on 06/17/14 PR2 from [REDACTED] (?), DC indicating that the patient had undergone a right sacroiliac joint injection on 05/16/14 with 40-50% benefit. Current medication shows as Prilosec 20mg 5 tablets per week, and Dendracine as needed. There are no further psychological or psychiatric records provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Monthly Psychotropic Medication Management and Approval: 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 & Stress, Office visits.

Decision rationale: There were no recent records provided for review. As such this request is not medically necessary. MTUS and ACOEM do not address psychotropic medication management. Per ODG, office visits are 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 ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payers for possible evaluation, however, payers should not automatically deny payment for these if preauthorization has not been obtained. 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.