

Case Number:	CM14-0061061		
Date Assigned:	07/09/2014	Date of Injury:	11/05/2008
Decision Date:	10/03/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	05/01/2014

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:

This is a 61-year-old male with a 10/5/08 date of injury; the mechanism of the injury was not described. The patient underwent right subtalar arthroscopic surgery on 11/2/09. The patient was seen on 4/8/14 with complaints of chronic right foot pain and chronic low back pain. The patient reported worsening of his depressive symptoms and that he was having more panic attacks. He denied any suicidal ideation. Exam findings revealed antalgic gait and the patient ambulated with assistance of a single crutch. The range of motion of the right foot was decreased by 60 % with flexion, 60 % with extension, and 80 % with inversion and eversion. Examination of the lumbar spine revealed tenderness to palpation at the lumbosacral junction and decreased range of motion. The request for 6 follow-up sessions with psychiatrist to evaluate the patient's antidepressant medication was made. The diagnosis is acquired deformity of ankle and foot, major depressive disorder single episode, chronic pain syndrome, anxiety. Treatment to date: acupuncture, LESI, PT, aqua therapy, crutches, chiropractic sessions, work restrictions and medications. An adverse determination was received on 4/15/14 given that the current request was for follow-up sessions with a psychiatrist and there was no documentation with psychiatric evaluation or any progress notes describing a treatment plan or goals.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six (6) Psychiatrist Follow-Up Sessions: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Office Visits

Decision rationale: CA MTUS does not specifically address the issue. ODG states that 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, to monitor the patient's progress, and make any necessary modifications to the treatment plan. 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 patient had depressive symptoms and anxiety attacks, but it is not clear if he was under psychiatric care. The progress note dated 4/8/14 stated that the psychiatric follow up was necessary to evaluate the patient's antidepressant medications, however there is a lack of documentation indicating that the patient was taking antidepressants. In addition, the progress note dated 4/14/14 indicated that the patient had CBT in the past and benefited from it, however there is a lack of documentation indicating how many sessions the patient attempted and there are no notes from the psychologist. The request was for 6 Psychiatrist follow-up sessions but there is no evidence that the patient was under psychiatric care. Therefore, the request for 6 Psychiatrist follow-up sessions was not medically necessary.