

Case Number:	CM14-0069302		
Date Assigned:	07/14/2014	Date of Injury:	07/30/1998
Decision Date:	08/29/2014	UR Denial Date:	04/25/2014
Priority:	Standard	Application Received:	05/14/2014

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, 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:

The injured worker is a 53 year old male whose date of injury is 07/30/1998 involving a slip and fall injury causing a back injury during the course of his employment as an auto mechanic. He subsequently underwent a laminectomy in 2002 followed by hardware removal and implantation of a spinal cord stimulator. He has had physical therapy. His diagnosis is major depressive disorder, single episode severe. His depressive symptoms include helplessness, hopelessness, and short term memory difficulties. In addition he complains of restlessness, muscle tension, excessive worrying, sleep disturbance, irritability, and concentration difficulties. A PR2 of 04/14/14 is the most recent psychiatric progress note. The patient reported that his depression has waxed and waned in severity. He continues to have difficulty taking pleasure in activities, his energy remains low with a lack of drive and motivation. He has suffered from intermittent panic attacks especially in the morning, with no clear precipitating factors. Symptoms of generalized anxiety disorder reported include restlessness, muscle tension, excess worrying, impaired sleep, irritability, and impaired concentration. Since starting psychiatric treatment with this provider these symptoms are reported to have improved by at least 60%, with sleep 30% improved, and 10% improvement in the areas of hygiene, personal activities, etc. Mental status exam shows mood as mildly depressed and anxious, affect congruent and appropriate. Feelings of helplessness and hopelessness are recurrent but recently improved. He denied suicidal ideation. Cognition was intact, as was judgment. Thought content was centered on chronic pain and disability. Registration and immediate recall were within normal limits, as was long term memory. He complained of some problems with short term memory. He rated his pain level as 8/10 (previously 6/10). Diagnostically he was given major depression single episode, panic disorder without agoraphobia, generalized anxiety disorder, lumbar radiculopathy, post lumbar laminectomy syndrome, and lumbosacral disc degeneration. The records show that the patient

has received prior psychotherapy, but there is no indication as to the number of sessions he has already received. There is reported subjective improvement after his previous psychotherapy treatment, but no evidence of significant objective functional improvement in records provided for review. Medications include Cymbalta 90mg daily, Wellbutrin XL 300mg daily, Mirtazapine 30mg at bedtime, Nuvigil 150mg -1 once per day as needed for daytime fatigue or drowsiness (using 1-2 times per month), Oxycontin 3 times per day, Voltaren topical gel as needed for pain, Flector patch as needed for pain, Norco 3 tablets daily, and promethazine 25mg twice per day as needed for GI upset. There are no baseline scales provided from which to assess the patient's symptoms of depression and anxiety, e.g. Beck Depression Inventory, Beck Anxiety Inventory, etc. In review of his monthly visits going back to 12/07/13 the findings are essentially the same each month, with the exception of having his Trazodone discontinued in 03/08.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient psychiatric visits; Once monthly x 5 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines; Cognitive Behavioral Therapy.

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: Per the ODG, office visits are recommended as determined to be medically necessary. 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 the patient's conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. Therefore, the request is not medically necessary and appropriate.