

Case Number:	CM15-0100946		
Date Assigned:	06/04/2015	Date of Injury:	09/12/2014
Decision Date:	07/09/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	05/26/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Texas

Certification(s)/Specialty: Psychiatry, Geriatric Psychiatry, Addiction Psychiatry

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 43 year old female, who sustained an industrial injury on 9/12/14 involving sexual harassment with subsequent development of psychiatric symptoms. She was given the diagnoses of anxiety disorder NOS and depressive disorder NOS. In 12/2014, she was hospitalized due to suicidal intent, was prescribed Klonopin and zolpidem, and was in psychotherapy twice per week. Regarding other medications, she reported that fluoxetine had no effect, Paxil gave her a rash, and the combination of Abilify and Xanax made her "mean". On 04/06/15, she was seen for an evaluation. The medical-legal UR report shows her diagnoses to be major depressive disorder (MDD) severe and PTSD. She complained of sleep disturbance, nightmares, fear, increased startle reflex, anxiety, guilt, distrust, fleeting thoughts of harming another, and depression. Until recently she had self harm behaviors in the form of cutting her arm with a razor blade. The thoughts of harming another revolved around a 10-month-old baby for whom her daughter babysat. The patient could not handle the noise, as such the daughter stopped babysitting. Her Beck Inventories were severe for both anxiety and depression. She had suicidal ideation but no plan or intent. She was not taking any prescribed medications, psychiatric or otherwise. Recommendations included Prazosin 5mg, and Wellbutrin XL 300mg to target MDD, for its anxiolytic properties to target the PTSD, and its energizing properties to aid with her amotivation and cognitive dysfunction.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Psychiatric Sessions: Upheld

Claims Administrator 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 and Stress, Online Version, Office Visits.

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 Chapter, Office Visits.

Decision rationale: According to the Official Disability Guidelines, 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. In this case, the patient has a history of either non-response/poor response, or side effects to her prescribed medications. As of 04/06/15, she was reportedly not taking any psychotropic medication. At that time she was prescribed Wellbutrin XL 300mg and Prazosin 5mg. There are no more recent records showing if she is compliant with this regimen, the efficacy, etc. Office visits are essential while a patient is on medications to monitor for side effects, efficacy, drug: drug interactions, clinical stability and any changes in the patient's status, etc. However, the frequency and number of these visits is based on the individual and what medication is prescribed as some require closer monitoring than others, what the patient's current condition is, etc. A set number or frequency of office visits cannot be predetermined. Therefore, the request is not medically necessary.