MAXIMUS Federal Services

Case Number:	CM15-0201854		
Date Assigned:	10/16/2015	Date of Injury:	11/04/2007
Decision Date:	12/01/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/14/2015

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 54 year old female who sustained an industrial injury on 11/4/2007. She is currently not working. She is being treated for a major depressive disorder, single episode in partial remission, insomnia, chronic pain, obesity, controlled hypertension and diabetes, impingement of right shoulder, discogenic cervical condition, carpal tunnel syndrome and wrist inflammation. She is status post decompression distal clavicle excision surgery (2009). At her physical exam of 07/29/2015 she had tenderness along the cervical paraspinal muscles, along the facets and pain with facet loading, pain in the right shoulder, rotator cuff, biceps tendon, and both knees. Gait was slightly antalgic and wide-based gait, and she used a cane. She was on Norco, Fentanyl, Neurontin, Flexeril, and Protonix. On 09/10/2015 she complained of unchanged mood, fair sleep on trazadone, no change in sadness, anxiety or irritability since her last visit. She reported anhedonia, worthlessness, poor concentration, attention and memory, increased appetite, hopelessness and helplessness. Her physical condition was unchanged. She reports no side effects from trazadone and attends group psychoeducation for anxiety and depression provided she has transportation. She has been on trazadone since at least 10/28/2014. On 09/22/2015 UR noncertified the requests for trazadone 150mg #90 with 2 refills; medication management monthly times 6, modified to monthly times 3; group cognitive behavioral therapy weekly for 6 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 150mg #90, 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Mental Illness & Stress Insomnia treatment.

Decision rationale: Trazodone is a sedating antidepressant often used in depressed patients suffering from insomnia. It does not have the limited use time guidelines of many of the nonbenzodiazepine sedative-hypnotics, or the potential for abuse and dependence of the benzodiazepines. The patient reports fair sleep on this agent, therefore justifying medical necessity. This request is medically necessary.

Medication management monthly x 6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress.

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

Decision rationale: 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. UR of 09/22/2015 modified a request for six visits to three. In addition, in this UR a follow up visit in two months was certified did not find documentation that these visits have been utilized as yet. This request is therefore not medically necessary.

Group CBT weekly x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment.

Decision rationale: Records show that the patient has had prior group therapy experience however the number was not specified. Evidence of objective functional improvement was not provided. It is unknown if she has exceeded guidelines in use or met guidelines in terms of meeting objectives. As such, this request is not medically necessary.