

<b>Case Number:</b>	CM13-0006590		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	02/07/2008
<b>Decision Date:</b>	01/16/2014	<b>UR Denial Date:</b>	07/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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 examinee states she has worked for a private party for about 30 years, as a Housekeeper and taking care of her children. The usual and customary duties of her job consisted of walking, lifting, bending, climbing ladders, kneeling, pushing and pulling, driving, shopping for groceries, laundry and cooking. She states some of the jobs she used to do, now she is not able to do. She had reported an injury that took place on February 7, 2008, while carrying out the usual and customary duties of her job, when she slipped on a grape and fell. The examinee stated that she was placed on light-duty schedule by [REDACTED], working only four hours per day. She received treatment for her left knee and her back pain. She came under the care of [REDACTED] (orthopedic surgeon) who eventually performed a left knee arthroscopy and medial and lateral meniscectomy. The examinee stated that she stayed off work for a period of one year subsequent to the left knee surgery. She has been given the following Axis I psychiatric diagnoses: Major Depression, Recurrent, in Partial Remission; Anxiety Disorder Not Otherwise Specified; Pain Disorder with Both Psychological Factors and General Medical Condition. She has been treated with psychiatric medications including atarax, citalopram and Prosom.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Eight (8) medication management sessions:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 27, 107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, office visits as well as the American Psychiatric Association Practice Guidelines for the Treatment of Patients with Major Depressive Disorder, Third Edition.

**Decision rationale:** The CA MTUS does not specifically address office visits for psychiatric medication management. The ODG does address office visits as follows: ODG, Mental Illness & Stress, Office Visits. 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 American Psychiatric Association Practice Guidelines: Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition DOI: 10.1176/appi.books.9780890423387.654001 states the following with respect to therapeutic interventions: "b. Assessing the adequacy of treatment response In assessing the adequacy of a therapeutic intervention, it is important to establish that treatment has been administered for a sufficient duration and at a sufficient frequency or, in the case of medication, dose [I]. Onset of benefit from psychotherapy tends to be a bit more gradual than that from medication, but no treatment should continue unmodified if there has been no symptomatic improvement after 1 month [I]. Generally, 4-8 weeks of treatment are needed before concluding that a patient is partially responsive or unresponsive to a specific intervention [II]." This reviewer notes that National standards of care require that the patient receives a minimum of eight medication management sessions over a twelve month period in order to assess the efficacy of the medications such as Atarax, Citalopram and Prosom. Not only does this patient need two medication management visits with a psychiatrist but will need ongoing psychiatric medication management visits with a psychiatrist over time for many reasons including but not limited to monitoring the patient for safety, efficacy of medications and monitoring for adverse effects such as increased suicidal ideation. Frequent visits would be needed to assess the patient's safety, overall condition and to monitor lab tests. In addition, the prescriber would need to collaborate with the entire health care team.

**Atarax 25mg, #60 with 2 refills between 6/21/13 and 9/16/13: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 402.

**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, Section on anxiety medications and chronic pain.

**Decision rationale:** The MTUS is silent about hydroxyzine for anxiety. The Official Disability Guidelines (ODG) Pain Chapter, Section on anxiety medications in chronic pain makes the following comment about the use of hydroxyzine: "Some other drug classes used to treat anxiety are antihistamines (e.g. hydroxyzine), 5HT1 agonist (e.g. buspirone), and some anti-epilepsy drugs. (Specific Treatment: FDA-approved indications are listed next to each specific drug. A note is made if a medication is used off-label.) (Hoffman, 2008)" Since hydroxyzine has

a very low potential for abuse and dependence, and because this particular patient has already been treated with ProSom, a hypnotic that does produce dependence, it is logical and safe that the patient continue on hydroxyzine (Atarax) as its continued use treat anxiety, and perhaps to some extent insomnia and also will make the weaning of ProSom easier for this particular patient.

**Citalopram 40mg, #30 with 2 refills between 6/21/13 and 9/16/13: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 402.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26, page(s) 107 has the following to state about SSRIs (selective serotonin reuptake inhibitors): "Not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. Selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRIs and pain. SSRIs have not been shown to be effective for low back pain. See Antidepressants for chronic pain for general guidelines, as well as specific SSRI listing for more information and references." This patient has suffered from depression and anxiety, and has been treated with hydroxyzine, citalopram and ProSom. The first two of these three medications do not produce dependence, and are safe and effective over very long periods of time. ProSom produces tolerance and dependence and guidelines recommend very short term use. Insomnia is often secondary to depression and anxiety. Continued use of citalopram will treat depression, anxiety and insomnia for this patient and facilitate the weaning of ProSom.

**ProSom 2mg, #30 with 2 refills between 6/21/13 and 9/16/13: 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, Benzodiazepines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

**Decision rationale:** ProSom (estazolam) is considered a benzodiazepine. According to the CA Chronic Pain Medical Treatment Guidelines 7-18-2009 on page 24/127, Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase

anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005). As such, ProSom is not medically necessary per CA MTUS guidelines.