

Case Number:	CM13-0011664		
Date Assigned:	09/24/2013	Date of Injury:	12/30/2009
Decision Date:	01/13/2014	UR Denial Date:	07/29/2013
Priority:	Standard	Application Received:	08/15/2013

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:

This case involves a 55 year old male who was injured on 12-30-09 while at work. The injury was severe, and grossly disfigured his dominant right hand. Most of his right hand was amputated. He has been married for over 35 years. He has suffered from low back pain, anxiety, depression, insomnia, neck pain, leg pain, stomach pain and headache. He has suffered from erectile dysfunction due to chronic pain. He has been treated psychiatrically including treatment with trazodone. He has been diagnosed with Major Depression as well as Post Traumatic Stress Disorder. He has been treated with the SSRI antidepressant medications Prozac and trazodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 100mg, #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation (ODG) Mental Illness and Stress Chapter, Trazodone.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines do not specifically address trazodone. However, Trazodone is an SSRI and the CA MTUS Chronic Pain

Medical Treatment Guidelines do note the value of SSRI medications being effective for depressive symptoms which the patient's record documents well. The Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, section on Trazodone does address the use of trazodone as follows: Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See also Insomnia treatment, where it says there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. See also Fibromyalgia in the Pain Chapter, where trazodone was used successfully in fibromyalgia. Trazodone was approved in 1982 for the treatment of depression. It is unrelated to tricyclic or tetracyclic antidepressants and has some action as an anxiolytic. Off-label uses include alcoholism, anxiety, insomnia, and panic disorder. Although approved to treat depression, the American Psychiatric Association notes that it is not typically used for major depressive disorder. Over the period 1987 through 1996, prescribing trazodone for depression decreased throughout the decade, while off-label use of the drug for insomnia increased steadily until it was the most frequently prescribed insomnia agent. To date, there has been only one randomized, double blind, placebo-controlled trial studying trazodone in primary insomnia. It was observed that relative to placebo, patients reported significant improvement in subjective sleep latency, sleep duration, wake time after sleep onset, and sleep quality with trazodone and zolpidem during week one, but during week two the trazodone group did not differ significantly from the placebo group whereas the zolpidem group demonstrated significant improvement compared to placebo for sleep latency and sleep duration. (Walsh, 1998) The AHRQ Comparative Effectiveness Research on insomnia concludes that trazodone is equal to zolpidem. (AHRQ, 2008) Evidence for the off-label use of trazodone for treatment of insomnia is weak. The current recommendation is to utilize a combined pharmacologic and psychological and behavior treatment when primary insomnia is diagnosed. Also worth noting, there has been no dose-finding study performed to assess the dose of trazodone for insomnia in non-depressed patients. Other pharmacologic therapies should be recommended for primary insomnia before considering trazodone, especially if the insomnia is not accompanied by comorbid depression or recurrent treatment failure. There is no clear-cut evidence to recommend trazodone first line to treat primary insomnia. (Mendelson, 2005) Given this patient's very significant depressive symptoms Trazodone seems very reasonable and is medically necessary.

Psychiatrist follow up #2: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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..

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. 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 Prozac and Trazodone. 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.

Cognitive behavioral individual or group therapy, #20: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

Decision rationale: The Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26, page 23 has the following to state about Behavioral interventions : Recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. See also Multi-disciplinary pain programs. ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone: - Initial trial of 3-4 psychotherapy visits over 2 weeks - With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions) This patient has severe injuries and severe depressive symptoms. The records provided to this reviewer do not show specific evidence of functional improvement. The voluminous medical records provided do include extensive psychological evaluation by [REDACTED], who details the patient's motivation and severe depressive symptoms combined with the patient's gruesome injury to his dominant hand. The CA MTUS guidelines are very clear that the total number of visits is "up to 6-10". Despite the patient's severe symptoms and strong motivation, the 20 sessions must be considered to be not medically necessary because of lack of documentation of functional improvement from psychotherapy done so far, and because 20 visits vastly exceeds the guideline total of 6-10 visits.