

Case Number:	CM13-0013571		
Date Assigned:	10/01/2013	Date of Injury:	07/18/1997
Decision Date:	03/18/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/19/2013

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 New York. 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.

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 disabled 45 year-old female who endured a series of traumatic workplace exposures in 2011 and 2012 while performing her usual and customary occupational duties as a property manager. The patient was assigned to manage dwellings in neighborhoods steeped with violence and criminal activity. She was exposed to gunshots, threatened by tenants, privy to hostage taking activity and witness to physical injuries. Prior to these exposures, the patient had no psychiatric history. She had not received treatment for psychological, emotional or chemical dependency issues. However, subsequent to said exposures, the patient began to feel stressed and overwhelmed with fearfulness, crying spells, panic attacks, fatigue, poor concentration, decreased appetite, mood liability, insomnia and somatic symptoms such as nausea, vomiting, headaches and dizziness. She had social withdrawal and displayed avoidance behaviors as well. On 10/9/12, the patient was diagnosed with acute stress reaction and referred for disability evaluation and transferred to psychology. The patient reportedly had a physician visit on 10/31/12 at which time posttraumatic stress disorder (PTSD) was diagnosed. Around that time, citalopram 10mg daily was initiated. The medication was not efficacious so she stopped taking it in mid-2013. On 12/15/12, the patient was diagnosed with adjustment disorder by a psychologist. On 3/11/13, the patient had psychological testing and was evaluated by a psychiatrist. She was diagnosed with PTSD versus anxiety disorder not otherwise specified (NOS). Weekly treatment for six months and medication re-assessment were recommended. On June 12, 2013, the patient had another psychological evaluation. She was diagnosed with PTSD versus anxiety disorder NOS, and rule out depressive disorder NOS. The patient participated in four therapy sessions between 6/12/13 - 7/10/13. She remained symptomatic. Thus an additional six sessions of individual therapy and biofeedback were certified. On July 31, 2013, she was evaluated by a psychiatrist and diagnosed with insomnia, PTSD and depressive disorder NOS. Individual psychotherapy combined with psychotropic medication (zolpidem for sleep and a serotonin-enhancer for anxiety and mood) was recommended. The patient was evaluated by a

psychiatrist on 8/5/13. Due to her persisting symptomatology, authorization was requested for six months of semi-monthly medication management office visits for treatment of PTSD. In response to the request, medication management office visits twice monthly for two months were certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medication management with psychotherapy and correlated reportings (twice monthly office visits) x 6 months quantity 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Office Visits and Cognitive Therapy for PTSD (updated 11/18/13). Management of Post-traumatic Stress Working Group (2010). VA/DOD Clinical Practice Guideline for Management of Post-traumatic Stress.

Decision rationale: Psychotropic medication management with psychotherapy represents a trusted intervention in the treatment armamentarium for those afflicted with posttraumatic stress disorder (PTSD). The most comprehensive parameter for PTSD treatment, the VA/DOD Clinical Practice Guideline, strongly recommends trauma focused cognitive therapy. In terms of pharmacotherapy, selective serotonin reuptake inhibitors (SSRI), and venlafaxine, represent first-line medication recommendations. Although medication therapy office visits are commonly front-loaded in the acute phase of illness and less often during maintenance, there is no evidence-based algorithm for frequency or duration of treatment. Per Official Disability Guidelines, "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." Further, the American College of Occupational and Environmental Medicine recommends antidepressant prescribing "in conjunction with specialty referral." Thus, medication management services provided by a psychiatrist are well within accepted practice standards and reasonably expected to improve the patient's condition and prevent a more serious illness. However, the need for bi-monthly medication-based office visits is not established in the record. The patient has only trialed one SSRI which was well-tolerated and very conservatively dosed. Incidentally, although all SSRIs are commonly used, the medication selected for that trial, citalopram, actually has no well-designed, adequately powered studies in the medical literature demonstrating its efficacy in the treatment of PTSD. Thus, unlike FDA approved paroxetine and sertraline, citalopram is not commonly used as a first-line medication by providers specializing in PTSD. In sum, the patient cannot be considered medication refractory and she does not have a complicated regimen. Thus, based on the documentation provided within the context of relevant peer reviewed literature and reference guidelines, two sessions of medication management for two months are initially reasonable.