

Case Number:	CM13-0018009		
Date Assigned:	10/11/2013	Date of Injury:	06/11/2004
Decision Date:	01/13/2014	UR Denial Date:	08/16/2013
Priority:	Standard	Application Received:	08/29/2013

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 patient is a fifty one year old male with a date of injury of 6/11/2004. According to available documentation the patient was under treatment for persistent depression with characteristic fearfulness and mistrust, episodes of uncontrollable crying, low self-esteem, diminished emotional control, impaired concentration and memory, and loss of energy. The patient's objective findings noted during the most recent evaluation with [REDACTED] on 7/19/13 included major impairments of emotional control, stress tolerance, energy, concentration, and short term memory. The patient was diagnosed with severe major depression with psychotic features. Recent treatment had included Medication management and supportive psychotherapy. The provider stated that the patient had plateaued with no further improvement expected. The provider stated that continued treatment was necessary to prevent worsening of symptoms and to provide symptomatic relief for the purpose of maintaining the patient's minimal level of function at home. In addition to depression, this patient has had lumbosacral sprain, headache, limps, and uses a cane. Under consideration are requests for Prozac 40 mg, Seroquel 100 mg, six cognitive behavioral group therapy sessions and one individual cognitive behavioral therapy session, Benadryl, Ativan and Haldol.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Prozac 40mg: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints, Chapter 15 Stress Related Conditions.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, section on antidepressants for major depression..

Decision rationale: Prozac is an Selective serotonin reuptake inhibitor (SSRI) antidepressant that seems to be helping the patient. Prozac is not specifically addressed in the The California Medical Treatment Utilization Schedule Section Chronic Pain medical treatment guidelines. The group of medications to which it belongs, the SSRI's, are addressed as follows: Not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. SSRI's are 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 SSRI's may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRI's and pain. SSRI's have not been shown to be effective for low back pain. See listing and references: The Official Disability Guidelines (ODG) does recommend Prozac as a first line agent for major depression. The ODG states the following about antidepressants for major depression: "Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. Professional standards defer somewhat to patient preference, allowing for a treatment plan for mild to moderate MDD to potentially exclude antidepressant medication in favor of psychotherapy if the patient favors such an approach. (American Psychiatric Association, 2006) A randomized controlled trial has indicated that the patient's smoking status is a credible factor that can be considered in the treatment plan. Specifically, antidepressant medication (fluoxetine/Prozac) has been found to compromise the success of smoking cessation efforts. (Spring, 2007) Consequently, if the patient is attempting to quit smoking, that effort causes antidepressant medication to be a less attractive treatment option than standards typically indicate (this consideration will be most relevant to presentations of MDD which are mild to moderate in current severity). Drug selection criteria. The American Psychiatric Association has published the following considerations regarding the various types of anti-depressant medications: (1) Many treatment plans start with a category of medication called selective serotonin reuptake inhibitors (SSRIs), because of demonstrated effectiveness and less severe side effects; Final Determination Letter for IMR Case Number CM13-0018009 4 (2) In addition to the SSRIs, other anti-depressant medications that are likely to be optimal for most patients include desipramine, nortriptyline, bupropion, and venlafaxine; (3) Another group of antidepressant medications, called monoamine oxidase inhibitors (MAOIs), are not recommended as a primary treatment option, because they are associated with serious side effects, and they necessitate dietary restrictions. This category

Six cognitive behavioral group psychotherapy sessions: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints, Chapter 15 Stress Related Conditions, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101-102. Decision based on Non-MTUS Citation ODG Cognitive Behavioral Therapy (CBT) Guidelines. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005)..

Decision rationale: In addition to depression, this patient has had lumbosacral sprain, headache, limps, and uses a cane. The CA MTUS Chronic Pain Treatment guidelines state the following about psychological treatment for pain: Psychological treatment: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested: "Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Final Determination Letter for IMR Case Number CM13-0018009 5 Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. (ODG Cognitive Behavioral Therapy (CBT) Guidelines.)" In the case of this patient there are additional risk factors including suicidal ideation and psychosis, both of which complicate his overall physical and mental health. He has responded well to psychological treatment and as such six cognitive behavioral therapy (CBT) group sessions are very reasonable and medically necessary.

One individual cognitive behavioral psychotherapy session: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints, Chapter 15 Stress Related Conditions, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101-102. Decision based on Non-MTUS Citation ODG Cognitive Behavioral Therapy (CBT) Guidelines. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005).

Decision rationale: In addition to depression, this patient has had lumbosacral sprain, headache, limps, and uses a cane. The California Medical Treatment Utilization Schedule Section Chronic Pain Treatment guidelines states the following about psychological treatment for pain: Psychological treatment: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining

appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested: "Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of Final Determination Letter for IMR Case Number CM13-0018009 6 goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. (ODG Cognitive Behavioral Therapy (CBT) Guidelines.)" In the case of this patient there are additional risk factors including suicidal ideation and psychosis, both of which complicate his overall physical and mental health. He has responded well to psychological treatment and as such six cognitive behavioral therapy (CBT) group sessions are very reasonable and medically necessary.

One prescription of Seroquel 100mg: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions, Chapter 14 Ankle and Foot Complaints, Chronic Pain Treatment Guidelines.

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 and Stress chapter, section on atypical antipsychotic.

Decision rationale: The California Medical Treatment Utilization Schedule Section Chronic Pain Medical Treatment guidelines, does not address the use of Seroquel. Official Disability Guidelines (ODG) Mental Illness and Stress chapter, Section Atypical Antipsychotics, does address the use of Seroquel and notes that it helps with depression. This patient suffers from psychotic depression including suicidal ideation. Seroquel is FDA approved both for psychosis as well as an add-on or augmentation agent to help the antidepressant, Prozac in this case, to work better.

One prescription of Benadryl 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints, Chapter 15 Stress Related Conditions, Chronic Pain Treatment Guidelines.

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 and Stress Chapter, Section on Antihistamines for Insomnia.

Decision rationale: Benadryl is not addressed by the The California Medical Treatment Utilization Schedule Section Chronic Pain Medical Treatment Guidelines. Benadryl is addressed in the Official Disability Guidelines as follows: "Sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine [Benadryl, OTC in U.S.], promethazine [Phenergan, prescription in U.S., OTC in other countries]). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. This RCT determined that diphenhydramine has been shown to build tolerance against its Final Determination Letter for IMR Case Number CM13-0018009 7 sedation effectiveness very quickly, with placebo-like results after a third day of use. (Richardson, 2002) Due to adverse effects, the U.S. National Committee for Quality Assurance (NCQA) has included diphenhydramine in the HEDIS® (Healthcare Effectiveness Data and Information) recommended list of high-risk medications to avoid in the elderly (NCQA, 2012)." Based upon this guideline, the efficacy of Benadryl for sleep is low, tolerance builds, and poses potential risks as detailed above.

One prescription of Ativan 1mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints, Chapter 15 Stress Related Conditions, Chronic Pain Treatment Guidelines.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section 8 C.C.R. Â§9792.20 - 9792.26, page 24 state the following: "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)." This patient has been on Ativan longer than 4 weeks and per the guideline listed above is not medically necessary.

One prescription of Haldol 5mg: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints, Chapter 15 Stress Related Conditions, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The California Medical Treatment Utilization Schedule and Official Disability Guidelines does not specifically address Haldol. ODG states in the Stress and Mental Illness Final Determination Letter for IMR Case Number CM13-0018009 8 Section under

Abilify : " Antipsychotics are the first-line psychiatric treatment for schizophrenia." This Patient suffers from psychosis in addition to depression. Generally accepted national standards of practice allow for the use of antipsychotic medications such as Haldol when psychotic symptoms do not respond to drugs like Seroquel. As such, Haldol is medically necessary to control psychosis and to decrease risk of suicide in this patient.