

Case Number:	CM13-0030042		
Date Assigned:	11/27/2013	Date of Injury:	09/25/2003
Decision Date:	02/05/2014	UR Denial Date:	09/19/2013
Priority:	Standard	Application Received:	09/26/2013

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 Neurology, has a subspecialty in Geriatric Psychiatry and Addiction Medicine 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.

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 35 year old male who sustained an industrial injury on 9/25/03. He was lifting heavy boxes when he experienced intense lower back pain. He was prescribed medications at that time and was released back to work with restrictions, but his lower back pain persisted. On or about 10/16/03 he sustained a 2nd industrial accident where he slipped off of a forklift and injured his left wrist. He was released back to work with restrictions, subsequently a left ganglion cyst was removed from his left wrist. He experienced residual pain in his left wrist. On or about 12/26/03 he sustained a 3rd industrial accident where he was hit by a forklift which went under his foot and pinned him between 2 forklifts. He experienced pain, swelling in his left foot which was subsequently cleaned and sutured; he had subsequent low back pain, left foot, left knee, and left wrist pain. In 2005 he sought psychiatric treatment at the [REDACTED], where he was apparently erroneously diagnosed with schizophrenia or bipolar disorder and was again prescribed medication. In approximately 2008 he underwent some sort of surgical procedure to his lower back but continued to experience low back pain and was apparently declared permanently disabled. His psychiatric condition continued to be poorly controlled and his temper remained labile, resulting in some form of brief prison sentence in 2010 after attacking his brother in law with a knife. By 2/20/13 he sought psychiatric consultation with [REDACTED] a licensed clinical psychologist and QME. [REDACTED] diagnosed the patient with major depressive episode single, generalized anxiety disorder, and hypoactive sexual desire. He also felt that the patient suffered from a sleep disorder. He began to treat him with cognitive behavioral therapy for his pain and depression. He noted the patient to be "unstable, apprehensive, restless, agitated, tired, and irritable". Notes between 2/13-9/13/13 we

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychiatric office visit with pharmacological management: Upheld

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

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 & Stress, Office Visits.

Decision rationale: Given the patient's evaluation in February 2013 with clearly elevated scores in anxiety and depressive realms, and what appears to be a gradually deteriorating functional course with an intercurrent incarceration due to impulsive behavior, a psychiatric evaluation is indicated for more appropriate management of this gentleman's pharmacologic regimen. To date it is not clear that he has had the optimum treatment for his illness and a comprehensive evaluation from a psychiatrist would be beneficial. CA-MTUS does not specifically address psychiatric office visits with medication management. Per ODG: 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 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. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits; however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004)

Psychotherapy sessions, two times for one month: Upheld

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

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

Decision rationale: According to CA-MTUS/ODG guidelines, cognitive behavioral therapy for depression is recommended on initial trial of 6 visits over 6 weeks with evidence of objective functional improvement. In this case the individual psychotherapy that has been afforded to the patient has no clear stated goal, nor has there been any clear overall functional progress which has been achieved from the sessions rendered (from progress notes provided). Therefore the request for individual psychotherapy sessions 2 times for one month is not medically necessary. CA-MTUS: 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). ODG-Recommended. Cognitive behavioral psychotherapy is a standard treatment for mild presentations of MDD; a potential treatment option for moderate presentations of MDD, either in conjunction with antidepressant medication, or as a stand-alone treatment (if the patient has a preference for avoiding antidepressant medication); and a potential treatment option for severe presentations of MDD (with or without psychosis), in conjunction with medications or electroconvulsive therapy. Not recommended as a stand-alone treatment plan for severe presentations of MDD. (American Psychiatric Association, 2006) See also Cognitive therapy for additional information and references, including specific ODG Psychotherapy Guidelines (number and timing of visits). Patient selection. Standards call for psychotherapy to be given special consideration if the patient is experiencing any of the following: (1) Significant stressors; (2) Internal conflict; (3) Interpersonal difficulties/social issues; (4) A personality disorder; & (5) A history of only partial response to treatment plans which did not involve psychotherapy. Types of psychotherapy. The American Psychiatric Association has published the following considerations regarding the various types of psychotherapy for MDD: Cognitive behavioral psychotherapy is preferable to other forms of psychotherapy, because of a richer base of outcome studies to support its use, and because it's structured and tangible nature provides a means of monitoring compliance and progress. In contrast

Seroquel 200 mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, (ODG)

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 & Stress, Quetiapine.

Decision rationale: The use of Seroquel in this case is completely unclear. As an antidepressant in major depression it is not a first line agent. It does have a role as a mood stabilizer in bipolar disorder however the patient has not been diagnosed with this illness. Its use in agitation as an "antiagitant" is off label, therefore there is no clear indication of why it is being employed for this claimant. Its use cannot be authorized in this case. The request is denied. CA-MTUS does not address Seroquel. Per ODG-Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (eg, quetiapine, risperidone) for conditions covered in ODG. See Atypical antipsychotics; & PTSD pharmacotherapy. See also Anxiety medications in chronic pain in the Chronic Pain Chapter. Atypical Antipsychotics: Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (eg, quetiapine, risperidone) for conditions covered in ODG. See PTSD pharmacotherapy. Adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms in adults, new research suggests. The meta-analysis also shows that the benefits of antipsychotics in terms of quality of life and improved functioning are small to nonexistent, and there is abundant evidence of potential treatment-related harm. The authors said that it is not certain that these drugs have a favorable benefit-to-risk profile. Clinicians should be very careful in using these medications. (Spielman, 2013) The American Psychiatric Association (APA) has released a list of specific uses of common antipsychotic medications that are potentially unnecessary and sometimes harmful. Antipsychotic drugs should not be first-line treatment to treat behavioral problems. Antipsychotics should be far down on the list of medications that should be used for insomnia, yet there are many prescribers using quetiapine (Seroquel), for instance, as a first line for sleep, and there is no good evidence to support this. Antipsychotic drugs should not be first-line treatment for dementia, because there is no evidence that antipsychotics treat dementia. (APA, 2013) Antipsychotic drugs are commonly prescribed off-label for a number of disorders outside of their FDA-approved indications, schizophrenia and bipolar disorder. In a new study funded by the National Institute of Mental Health, four of the antipsychotics most commonly prescribed off label for use in patients over 40 were found to lack both safety and effectiveness. The four atypical antipsychotics were aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), and risperidone (Risperdal). The authors concluded that off-label use of these drugs in people over 40 should be short-term, and undertaken with caution. (Jin, 2013).