

<b>Case Number:</b>	CM13-0046505		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	10/05/2005
<b>Decision Date:</b>	03/14/2014	<b>UR Denial Date:</b>	10/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2013

### 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 Child and Adolescent 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. 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 disabled 47 year-old male who sustained a work-related injury on October 5, 2005. The patient suffers from persisting pain in addition to gastrointestinal symptomatology and sleep apnea. The patient had no reported prior psychiatric history but subsequent to his injury, he became depressed and anxious. He was diagnosed with adjustment disorder with mixed anxiety and depression and began psychotherapy in 2010. Although unsure of the exact date, by 2012 the patient was prescribed psychotropic medications. His most recent regimen consisted of fluoxetine 20mg daily, lorazepam 0.5mg every morning, zolpidem 10mg at bedtime and sildenafil 100mg as needed. His anxiety worsened in mid-2013 in anticipation of a surgical procedure. In August 2013, the diagnosis of adjustment disorder was changed to major depressive disorder, in addition to his diagnoses of insomnia and male hypoactive sexual desire disorder. The request for monthly psychotropic medication management and medication approval was non-certified on 10/16/13 and upheld on appeal.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Six monthly psychotropic medication management sessions:** 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; American Psychiatric Association. (2010). Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition. Washington, DC: Gelenberg AJ, et al.; and

**Decision rationale:** Psychotropic medication management represents a trusted intervention in the treatment armamentarium for those afflicted with major depressive disorder. According to the American Psychiatric Association Treatment Guideline, "Patients should be carefully and systematically monitored on a regular basis to assess their response to pharmacotherapy, identify the emergence of side effects ... and assess patient safety." Further, according to the American College of Occupational and Environmental Medicine, "Antidepressant or antipsychotic medication may be prescribed for major depression or psychosis; however, this is best done in conjunction with specialty referral." 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 ODG, "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." 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, there is no mention of patient distress or decompensation of functionality. He has been prescribed psychotropic medications for at least two years, so the safety and tolerability of the regimen has been established. Finally, the dosing is modest and the regimen is not complicated. Thus, based on the documentation provided within the context of relevant peer reviewed literature, trusted practice parameters and occupational guidelines, a frequency of monthly medication visits is not medically necessary.

**Medication approval:** 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): 16 and 24 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Procedure Summary; American Psychiatric Association. (2010). Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition. Washington, DC: Gelenberg AJ, et al.;

**Decision rationale:** Although some of the current medications are medically necessary, the request is for unspecified medications, which may include all the current medications as well as others. The medical necessity for all current medications, as well as possibly others, has not been established. Fluoxetine: Per Medical Treatment Utilization Schedule (MTUS), "It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain." Official Disability Guidelines (ODG) recommend fluoxetine "as a first-line treatment option for major depressive disorder." These recommendations align with the American Psychiatric Association (APA) and the Kaplan and Sadock reference text. Treatment

with fluoxetine is medically necessary. Sildenafil: This intervention is not mentioned in MTUS or ODG. However, sildenafil is recommended for both sexual arousal and erectile dysfunction. The patient is diagnosed with hypoactive sexual desire disorder. Treatment with sildenafil is medically necessary. Lorazepam: Per MTUS, benzodiazepines are "not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Benzodiazepine therapy for depression is not mentioned in ODG. Per the APA, benzodiazepines may have a role in treating catatonia associated with major depression or comorbid anxiety disorders. However, this patient is not diagnosed with a contemporaneous anxiety disorder and "these agents do not treat depressive symptoms." Lorazepam is not medically necessary. Zolpidem: Per ODG, "Zolpidem is approved for the short-term (usually two to six weeks) treatment of insomnia," and it is "not recommended for long-term use." Cognitive behavioral therapy for insomnia and sleep hygiene practices represent well-researched non-pharmacologic interventions with durable effects. There are other medication options more suitable for the long-term treatment of insomnia. Treatment with zolpidem is not medically necessary.