

<b>Case Number:</b>	CM13-0067769		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	06/22/2005
<b>Decision Date:</b>	04/07/2014	<b>UR Denial Date:</b>	12/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2013

### 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 and Texas. 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:

Records reviewed include 154 pages of administrative and medical records. The injured worker is a 48 year old male with the diagnosis of major depressive disorder, single episode, mild. His date of injury was 06/22/2005. 12/30/2013 Request for Treatment Authorization, medical-legal supplemental report: response to utilization review denial/modification, [REDACTED]. The patient's course of treatment was reviewed. He had industrial injuries prior to this claim; however these did not involve psychiatric components. He was initially diagnosed with bilateral carpal tunnel syndrome. With his lack of physical improvement he became depressed and anxious, more easily angered, irritable and socially withdrawn, had diminished libido, difficulty concentrating and focusing attention. His pain worsened and radiated to both elbows and shoulders. He then sought psychiatric treatment at [REDACTED] where he was prescribed Prozac and psychotherapy. He was ultimately diagnosed with major depressive disorder single episode, mild by [REDACTED] group, where he received another course of psychotherapy. He notes that in a prior report the patient's sleep was described as interrupted and disturbed by pain, leaving him fatigued and lacking in energy. He further points out that the IW had reached maximal medical improvement as of 12/17/2007. [REDACTED] reported that the patient's symptoms included anxiety and depression manifested by being easily angered, irritable, socially withdrawn, tearful, less motivation to be active, and lower self-esteem and self-confidence. Sleep was reported to be broken at about 4 hours per night. He had difficulty concentrating, remembering and focusing attention. The patient was said to be experiencing auditory and visual hallucinations, and believed that he was being followed. Medications as of this report (prescribed by [REDACTED], MD) were Effexor XR 75mg, Latuda 120mg, Zyprexa 20mg nightly, Risperdal 2mg twice daily, Lunesta 3mg nightly. [REDACTED] outlined the patient's medication treatment course with [REDACTED].

as follows: 01/2012: The patient's depression and psychotic symptom were "unchanged" and he was sleeping 4-5 hours per night, medications were helpful. 03/2012: Patient remained depressed and was hearing voices daily, sleeping about 4 hours per night. Prescribed Prozac, Risperdal, Zyprexa, Ambien CR. 04/2012: Discontinued Ambien, increased Zyprexa dose. 05/2012: Increased Lunesta dose. 07/2012: Sleeping about 4 hours. 09/2012: Discontinued Lunesta, added Seroquel. Remained depressed and continued to hear voices and see visions. Sleeping 3-4 hours per night. 10/2012: Increased dose of Seroquel. 10/2012: Expressed belief that someone wants to hurt him. Latuda added, discontinued Seroquel, resumed Lunesta. 01/2013: Increased Latuda dose. Sleeping 4-5 hours. 06/2013: no longer heard voices, remained tearful and depressed, sleeping 4 hours a night. Medications were Prozac, Latuda, Zyprexa, Risperdal, and Lunesta. July 2013: Discontinued Prozac. IW remained depressed, continued to hear voices and see visions, believed he was being followed. Prescribed Wellbutrin. 09/2013: Sleeping 4-5 hours. Increased Wellbutrin to 300mg. 10/2013: discontinued Wellbutrin and added Effexor. It is unclear when Effexor was discontinued and Wellbutrin was resumed. There were no psychiatry notes or reports submitted for review to support the use of multiple antipsychotics.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Wellbutrin XL 300 1 in the a.m. #35:** 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) and American Psychiatric Association, Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition

**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, Antidepressants for treatment of MDD (major depressive disorder)

**Decision rationale:** MTUS/ACOEM do not address Wellbutrin or major depressive disorder specifically, therefore ODG was used to formulate this decision. Per ODG, antidepressants are 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. Antidepressants offer significant benefit in the treatment of the severest depressive symptoms but may have little or no therapeutic benefit over and above placebo in patients with mild to moderate depression. A recent meta-analysis concluded that drug effects were nonexistent to negligible among depressed patients with mild, moderate, and even severe baseline symptoms, whereas they were large for patients with very severe symptoms, but the majority of depressed patients presenting for treatment do not fall into that very severe category. The patient's diagnosis is major depressive disorder, single episode, mild. His symptoms described were anxiety and depression manifested by being easily angered, irritable, socially withdrawn, tearful, feeling less motivated to be active, and self-esteem and self-confidence being low, with sleep disruption, difficulty concentrating/remembering and focusing attention. This is somewhat incongruous in light of the described psychotic features and persecutory delusions. He was also

experiencing auditory and visual hallucinations, believing he was being followed. From [REDACTED] outline above, it is unclear what [REDACTED] rationale was for prescribing Wellbutrin. The patient was started on Prozac in 2012. This was discontinued in July 2013, at which time Wellbutrin was added. In September 2013 the Wellbutrin dose was increased. In 10/13 it was discontinued, Effexor was started. It is unclear when Effexor was discontinued and Wellbutrin was resumed. No psychiatric records were submitted showing what symptoms were being addressed, was there any functional improvement, side effects, etc. Furthermore, it is unknown what the outcome of his prior psychotherapy was in terms of benefit, functional improvement, etc. Without these records medical necessity cannot be determined, as such, this request is noncertified.

### **Latuda 120 1 at bedtime #35: 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) and American Psychiatric Association, Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition

**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, Atypical Antipsychotics

**Decision rationale:** MTUS/ACOEM do not address Latuda or atypical antipsychotics, therefore ODG was utilized in the formulation of this decision. Per ODG, atypical antipsychotics are not recommended as a first line treatment as there is insufficient evidence for use in conditions in ODG. They are FDA approved for schizophrenia and bipolar disorder, the patient has been diagnosed with neither. New research suggests that adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms, and the meta-analysis shows abundant evidence of potential treatment related harm. They should be far down the list for use in insomnia. A study funded by the National Institute of Mental Health found that 4 of the antipsychotics most commonly prescribed for off label use in patients over 40 lacked both safety and effectiveness, two of which were Zyprexa and Risperdal. With the addition of Latuda, this man is now on 3 atypical antipsychotics, which further places him at risk for untoward side effects such as EPS. The patient was diagnosed with major depressive disorder single episode, mild. He later developed auditory and visual hallucinations, which do not appear to be related to the depressive disorder. In fact, no clear etiology was established in this IW for the emergence of psychotic symptoms. In a case such as this the most usual explanation would be major depression with psychotic features, or a transient psychotic reaction. However, neither condition is proffered as an explanation for the patient's clinical status. The auditory component was not described, visual was said to be "seeing visions". There appeared to be a paranoid component in the form of feeling that he was "being followed". He was never given a diagnosis of a psychotic disorder, nor was his depressive disorder changed to a psychotic depression. In this IW's case it appears that an antipsychotic would be prescribed to treat the psychotic symptoms, although it is well known that they are used off-label to augment antidepressants in the treatment of major depressive disorder. In this case however, no clear-cut rationale was given for either. In [REDACTED] outline of the medication treatment plan above, in 03/12 the patient was hearing voices

daily and was on Risperdal and Zyprexa. In 04/12 the Zyprexa was increased. In 10/12 Latuda was added, and it was increased in 01/13. He now appears to be on 3 atypical antipsychotics, all without documentation of need. No psychiatric records were submitted for review. Medical necessity cannot be determined, as such this request is noncertified.

**Zyprexa 20mg 1 BID #70:** 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) and American Psychiatric Association, Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition

**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, Atypical Antipsychotics; Olanzapine (Zyprexa)

**Decision rationale:** MTUS/ACOEM do not address Zyprexa or atypical antipsychotics, therefore ODG was utilized in the formulation of this decision. Per ODG, atypical antipsychotics are not recommended as a first line treatment as there is insufficient evidence for conditions covered in ODG. They are FDA approved for schizophrenia and bipolar disorder, the patient has been diagnosed with neither. New research suggests that adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms, and the meta-analysis shows abundant evidence of potential treatment related harm. They should be far down the list for use in insomnia. A study funded by the National Institute of Mental Health found that 4 of the antipsychotics most commonly prescribed for off label use in patients over 40 lacked both safety and effectiveness, two of which were Zyprexa and Risperdal. With the addition of Latuda, this man is now on 3 atypical antipsychotics, which further places him at risk for untoward side effects such as EPS. The patient was diagnosed with major depressive disorder single episode, mild. He later developed auditory and visual hallucinations, which do not appear to be related to the depressive disorder. In fact, no clear etiology was established in this injured worker (IW) for the emergence of psychotic symptoms. In a case such as this the most usual explanation would be major depression with psychotic features, or a transient psychotic reaction. However, neither condition is proffered as an explanation for the patient's clinical status. The auditory component was not described, visual was said to be "seeing visions". There appeared to be a paranoid component in the form of feeling that he was "being followed". He was never given a diagnosis of a psychotic disorder, nor was his depressive disorder changed to a psychotic depression. In this IW's case it appears that an antipsychotic would be prescribed to treat the psychotic symptoms, although it is well known that they are used off-label to augment antidepressants in the treatment of major depressive disorder. In this case however, no clear-cut rationale was given for either. In [REDACTED]' outline of the medication treatment plan above, in 03/12 the patient was hearing voices daily and was on Risperdal and Zyprexa. In 04/12 the Zyprexa was increased. In 10/12 Latuda was added, and it was increased in 01/13. He now appears to be on 3 atypical antipsychotics, all without documentation of need. No psychiatric records were submitted for review. Medical necessity cannot be determined, as such this request is noncertified.

**Risperdal 2mg 1 BID #70:** 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) and American Psychiatric Association, Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition

**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, Atypical Antipsychotics; Risperidone

**Decision rationale:** MTUS/ACOEM do not address Risperdal or atypical antipsychotics, therefore ODG was utilized in the formulation of this decision. Per ODG, atypical antipsychotics are not recommended as a first line treatment as there is insufficient evidence for conditions covered in ODG. They are FDA approved for schizophrenia and bipolar disorder, the patient has been diagnosed with neither. New research suggests that adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms, and the meta-analysis shows abundant evidence of potential treatment related harm. They should be far down the list for use in insomnia. A study funded by the National Institute of Mental Health found that 4 of the antipsychotics most commonly prescribed for off label use in patients over 40 lacked both safety and effectiveness, two of which were Zyprexa and Risperdal. With the addition of Latuda, this man is now on 3 atypical antipsychotics, which further places him at risk for untoward side effects such as EPS. The patient was diagnosed with major depressive disorder single episode, mild. He later developed auditory and visual hallucinations, which do not appear to be related to the depressive disorder. In fact, no clear etiology was established in this IW for the emergence of psychotic symptoms. In a case such as this the most usual explanation would be major depression with psychotic features, or a transient psychotic reaction. However, neither condition is proffered as an explanation for the patient's clinical status. The auditory component was not described, visual was said to be "seeing visions". There appeared to be a paranoid component in the form of feeling that he was "being followed". He was never given a diagnosis of a psychotic disorder, nor was his depressive disorder changed to a psychotic depression. In this IW's case it appears that an antipsychotic would be prescribed to treat the psychotic symptoms, although it is well known that they are used off-label to augment antidepressants in the treatment of major depressive disorder. In this case however, no clear-cut rationale was given for either. In [REDACTED] outline of the medication treatment plan above, in 03/12 the patient was hearing voices daily and was on Risperdal and Zyprexa. In 04/12 the Zyprexa was increased. In 10/12 Latuda was added, and it was increased in 01/13. He now appears to be on 3 atypical antipsychotics, all without documentation of need. No psychiatric records were submitted for review. Medical necessity cannot be determined, as such this request is noncertified.

**Lunesta 3mg 1 at bedtime #35:** 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) and American Psychiatric Association, Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition

**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:** It is unclear from records provided what the rationale is for prescribing Lunesta, or what other measures, if any, were attempted prior to prescribing pharmacologic agents to treat this patient's insomnia. [REDACTED] report shows that in 2012 the IW was tried on Ambien CR which was discontinued, the Lunesta was increased, and then discontinued, Seroquel was added and then discontinued, and Lunesta was then resumed. There is no description of functional improvement, or lack thereof. Records should reflect the quality of the patient's sleep, difficulty falling/staying asleep, mid-sleep awakening, early morning awakening, etc. This provides a very confusing clinical picture and without psychiatric office visit records it is difficult to discern [REDACTED] rationale for prescribing Lunesta and to assess its medical necessity. As such, this request is noncertified.