

<b>Case Number:</b>	CM13-0070888		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	01/26/2007
<b>Decision Date:</b>	04/22/2014	<b>UR Denial Date:</b>	12/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 expert 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 66 year-old female with a date of injury of 01/26/2007. The listed diagnoses per [REDACTED] are post traumatic disorder, depression, anxiety and sleep problems. According to report dated 10/31/2013 by pain management physician, [REDACTED], the patient presents for medication management. Patient's emotional symptoms have persisted to the extent that it has become essential to maintain psychological functioning with psychotropic medication for depression (Bupropion), anxiety (Xanax), sleep issues (Prosom), and panic attacks (Xanax). The treating physician goes on to state that standard medications for the patient's issues would be insufficient in subduing patient's mental instability and inability to adequately control her emotions. It is further noted that these "maintenance medications would be required for the foreseeable future." The plan would be to review her medications with medication management sessions every three months. Treating physician is requesting medication management sessions and refills of medications. Patient medications include Ambien, fioricet, relpax, prosom, wellburtrin, Xanax, Bupropion, Seroquel, and Alprazolam.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FIORICET #60 WITH 2 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** This patient presents for medication management and suffers from post traumatic disorder, depression, anxiety and sleep issues. The treating physician is requesting Fioricet #60 with 2 refills. For barbiturate-containing analgesic (BCA) agents, the MTUS Guidelines do not recommend for chronic pain. "The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents (meclizine 2000)". There is a risk of medication overuse as well as rebound headache. The requested Fioricet is not medically necessary and recommendation is for denial.

**RELPAK 40MG #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS 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:** This patient presents for medication management and suffers from post traumatic disorder, depression, anxiety and sleep issues. The treating physician is requesting Relpax. The MTUS and ACOEM guidelines do not discuss Relpax. However, ODG guidelines have the following regarding triptans for headaches: "Recommended for migraine sufferers. At marketed doses, all oral triptans (e.g., Sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients." As medical records document, this patient has "stress-intensified headaches that extend to migraine proportions." The patient has been taking this medication since 05/28/2013. In this case, Relpax may be indicated if the patient truly suffers from migraines. However, a diagnosis of migraine is not clear and the patient appears to suffer from tension-type or stress induced or traumatic brain injury related headaches. Furthermore, the treating physician does not provide any documentation regarding the efficacy of this medication as related to the patient's headaches. MTUS page 60 requires documentation of pain assessment and functional improvement when medication is used for chronic pain. Recommendation is for denial.

**PROSOM 2MG #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, Mental Illness & Stress

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

**Decision rationale:** This patient presents for medication management and suffers from post traumatic disorder, depression, anxiety and sleep issues. The treating physician is prescribing Prosom as a sleep medication. Prosom is a benzodiazepine derivative. The MTUS guidelines

page 24 states, "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." This patient has been taking this medication since 05/28/2013. MTUS guidelines are very clear on long term use benzodiazepines and recommends maximum use of 4 weeks due to "unproven efficacy and risk of dependence." In addition, the patient is concurrently prescribed Ambien without any discussions as to why two sleep medications are needed. Recommendation is for denial.

**Alprazolam 0.5mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** This patient presents for medication management and suffers from post traumatic disorder, depression, anxiety and sleep issues. The treating physician is requesting Alprazolam for the patient's anxiety. Utilization review dated 12/11/2013 modified certification from #120 to #95. The MTUS guidelines page 24 states, "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." Medical records indicate this patient has been taking this medication since 05/28/2013. MTUS does not support long term use of benzodiazepines. Recommendation is for denial.

**SEROQUEL 25MG #60: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress

**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:** This patient presents for medication management and suffers from post traumatic disorder, depression, anxiety and sleep issues. The treating physician is requesting Seroquel 25mg #60. Utilization review dated 12/11/2013 denied the request stating prior review already certified this request on 11/26/2013. The ACOEM and MTUS do not discuss Seroquel specifically. However, ODG guidelines have the following regarding atypical antipsychotic medications: "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 [post traumatic stress disorder] 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 treating physician is requesting this medication stating the

patient "will likely be unable to concentrate sufficiently to maintain emotional functioning and will likely remain emotionally overwhelmed and prone to mental deterioration" without a major tranquilizer such as Seroquel. In this case, ODG does not recommend this medication. The benefits are noted as "small to nonexistent" with "abundant evidence of potential treatment-related harm." In addition, as medical records document the patient is taking antidepressants, anti-anxiety medication, multiple sleeping aids and multiple benzodiazepines. It would be difficult to measure the efficacy of this specific medication as multiple sedating agents are prescribed. Recommendation is for denial.

**4 MEDICATION MANAGEMENT SESSIONS, ONCE EVERY 3 MONTHS FOR THE NEXT YEAR OR MORE: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 203.

**Decision rationale:** This patient presents for medication management and suffers from post-traumatic disorder, depression, anxiety and sleep issues. ACOEM, chapter 12, pg 303 has the following regarding Follow-up Visits: "Patients with potentially work-related low back complaints should have follow up every three to five days by a midlevel practitioner or physical therapist who can counsel the patient about avoiding static positions, medication use, activity modification, and other concerns." ACOEM further states, "physician follow-up might be expected every four to seven days if the patient is off work and seven to fourteen days if the patient is working." In this case, ACOEM allows for follow up visits and medication management every 3 months is reasonable given the patient long history of multiple medication use. MTUS page 8 also talks about physician monitoring for management of chronic pain. Recommendation is for approval.