

<b>Case Number:</b>	CM14-0003726		
<b>Date Assigned:</b>	01/31/2014	<b>Date of Injury:</b>	05/14/2003
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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 Anesthesiology, 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 31-year-old male who has submitted a claim for major depressive disorder with suicide ideation, lumbar radiculitis, and chronic pain syndrome associated with an industrial injury date of May 14, 2003. Medical records from 2010 to 2013 were reviewed showing that patient complained of changes in appetite, lack of interest, and movement changes. Patient manifested with low energy. Patient tried to commit suicide in 2011, and was subsequently admitted in a psychiatric hospital. Patient likewise complained of persistent low back pain radiating into right lower extremity associated with numbness, tingling, and weakness. Pain was graded 7 to 9/10 and aggravated by prolonged walking, bending, twisting, prolonged sitting, and standing. He had difficulty with ambulation requiring the use of a cane. Physical examination showed tenderness and spasm of the paralumbar muscles. Range of motion was restricted and painful. Sitting root test, Kemp's test, and Bragard's test were positive at the right. Muscle strength and reflexes were decreased at the right lower extremity. Sensation was diminished below the right knee. Treatment to date has included endoscopic lumbar disc surgery in 2006, physical therapy, and medication such as gabapentin, Cymbalta, Naprosyn, omeprazole, tramadol. The utilization review from December 24, 2013 denied the requests for melatonin 5 mg, one to two nightly; Neurontin 400 mg b.i.d.; Seroquel 100 mg nightly; transportation to all medical appointments; 24/7 home care assistance by tech or LVN; and group therapy one times per week x 12 weeks. Reasons for the denial were not made available. The request for individual cognitive behavior therapy once a week x 12 weeks was denied because there was no documentation of the number of sessions completed and objective functional improvement with previous therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MELATONIN 5MG:** 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 Food And Drug Administration, Melatonin Section.

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Mental and Illness Section was used instead. It states that cognitive therapy for depression is recommended. Psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. With evidence of symptom improvement, a total of up to 13 - 20 visits over 7 - 20 weeks is recommended. In this case, patient underwent individual cognitive behavior therapy sessions since 2012. Medical records submitted and reviewed failed to provide evidence concerning the total number of sessions he had and functional outcomes derived from it. It is significant to determine his response to psychotherapy to warrant continuation of such. The medical necessity has not been established. Therefore, the request for individual cognitive behavior therapy one (1) time a week for twelve (12) weeks is not medically necessary.

**NEURONTIN 400MG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, GABAPENTIN (NEURONTIN), 49

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17.

**Decision rationale:** Pages 16-17 of CA MTUS Chronic Pain Medical Treatment Guidelines state that Gabapentin is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. In this case, patient has persistent low back pain radiating to the right lower extremity, consistent with neuropathic pain. He has been on Gabapentin since 2012; however, medical records submitted and reviewed do not provide evidence of functional benefits derived from it. In addition, the request failed to specify the quantity to be dispensed. The request is incomplete, therefore, the request for Neurontin 400 mg is not medically necessary.

**SEROQUEL 100MG:** 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 Food And Drug Administration, Seroquel Section.

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Food and Drug Administration was used instead. It states that Seroquel is indicated for acute treatment of manic episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex; and monotherapy for the acute treatment of depressive episodes associated with bipolar disorder. In this case, patient has major depressive disorder with suicidal ideation, diagnosed since 2011. The earliest progress report citing the prescription for Seroquel is dated October 2013. However, the most recent progress report in December 2013 failed to document the response from it. In addition, the request failed to specify the quantity to be dispensed. The request is incomplete, therefore, the request for Seroquel 100 mg is not medically necessary.

**TRANSPORTATION TO ALL MEDICAL APPTS.:** 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 The Official Disability Guidelines (ODG)

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Knee Chapter was used instead. ODG states that transportation to and from medical appointments is recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. In this case, a progress report, dated 10/29/2013, cited that patient had limited ability to walk and he required a cane for ambulation. His pain likewise interfered with his ability to travel. The medical necessity for transportation has been established. However, the present request failed to specify a limited duration of time necessitating such service. Frequent evaluation of patient's impairments and activity limitations is needed to determine extension of services. Therefore, the request for transportation to all medical appointments is not medically necessary.

**24/7 HOME CARE ASSISTANCE BY TECH OR LVN:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, HOME HEALTH SERVICES, 51

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

**Decision rationale:** As stated on page 51 of CA MTUS Chronic Pain Medical Treatment Guidelines, home health services are only recommended for otherwise recommended medical

treatment for patients who are homebound, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. In this case, a progress report, dated September 14, 2011, cited that patient did not require a 24/7 home care. The most recent progress reports, however, do not provide evidence that the patient currently has a need for such service. There is no clear indication in the medical records provided that the patient has a need of professional nursing services for the purposes of home health. Furthermore, the guidelines only recommend home health assistance up to no more than 35 hours per week. The present request exceeded the guideline recommendation. Therefore, the request for 24/7 home care assistance by tech or lvn is not medically necessary.

**GROUP THERAPY ONE (1) TIME A WEEK FOR TWELVE (12) WEEKS: 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), Mental Illness And Stress Chapter, Group Therapy and Psychotherapy Sections.

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Mental Illness and Stress Chapter was used instead. It states that group therapy should provide a supportive environment in which a patient with post-traumatic stress disorder may participate in therapy with other patients. Psychotherapy guidelines recommend an initial trial of 6 visits over 3 to 6 weeks. In this case, patient presented with changes in appetite, lack of interest, low energy, etc. Psychotherapy may be necessary in this case. However, the present request of 12 sessions exceeded the guideline recommendation of an initial trial of 6 visits. Therefore, the request for group therapy one (1) time a week for twelve (12) weeks is not medically necessary.

**INDIVIDUAL COGNITIVE BEHAVIOR THERAPY ONE (1) TIME A WEEK FOR TWELVE (12) WEEKS: 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), Mental Illness And Stress Chapter, Cognitive Therapy For Depression Section.

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Mental and Illness Section was used instead. It states that cognitive therapy for depression is recommended. Psychological

treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. With evidence of symptom improvement, a total of up to 13 - 20 visits over 7 - 20 weeks is recommended. In this case, patient underwent individual cognitive behavior therapy sessions since 2012. Medical records submitted and reviewed failed to provide evidence concerning the total number of sessions he had and functional outcomes derived from it. It is significant to determine his response to psychotherapy to warrant continuation of such. The medical necessity has not been established. Therefore, the request for individual cognitive behavior therapy one (1) time a week for twelve (12) weeks is not medically necessary.