

<b>Case Number:</b>	CM14-0031660		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	01/30/2004
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	03/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2014

### 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 Family Medicine and is licensed to practice in Arizona. 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:

This patient is a 60 year old female with a date of injury on 1/30/2004. Diagnoses include major depressive disorder, chronic pain, physical injury, and financial hardship. The patient is status post left knee surgery on 10/1/2013. Subjective complaints are of increased anxiety and insomnia, daily depression, and decreased energy and memory. Physical exam shows a slightly dysphoric, sad, and anxious patient with constricted affect. There was no paranoia or delusions noted. Records also indicate that the patient has a two sessions of transcranial magnetic stimulation, and it was noted that patient had failed multiple antidepressants, and therapy modalities. Subsequent utilization review modified request for 6 additional TMS sessions. Medications include Seroquel, Effexor, and Trazodone. The patient had been attending group psychotherapy, of which the total number of sessions was not documented in the records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continue rTMS treatment times eighteen sessions:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MENTAL HEALTH, TRANSCRANIAL MAGNETIC STIMULATION.

**Decision rationale:** The ODG states that transcranial magnetic stimulation (TMS) is under study for PTSD, with initial promising results. Studies show that depression and anxiety scores were significantly improved after this treatment. For this patient, documentation indicates resistant depression that has failed to respond to medications, and psychotherapy. Therefore, the use of TMS is appropriate for this patient, and the medical necessity is established.

**Serquel 200mg #60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions. Decision based on Non-MTUS Citation ODG) 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 Other Medical Treatment Guideline or Medical Evidence: FDA: SEROQUEL [www.drugs.com](http://www.drugs.com).

**Decision rationale:** FDA prescribing guidelines indicate that Seroquel is used together with antidepressant medications to treat major depressive disorder in adults. For this patient, documentation indicates resistant depression that has failed to respond to medications, and psychotherapy. Therefore, due to resistant depression the use of Seroquel is consistent with prescribing guidelines, and is medically necessary for this patient.

**Effexor 225mg #90:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-14.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS Page(s): 14-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MENTAL HEALTH, ANTIDEPRESSANTS.

**Decision rationale:** CA MTUS and the ODG recommend the use of Effexor as a treatment for chronic pain especially if pain is accompanied by insomnia, anxiety, or depression. CA MTUS acknowledges that specifically for lumbar radiculopathy, there are no high quality studies that demonstrate efficacy. This patient has chronic pain, and concurrent depression and anxiety. Therefore, the use of Effexor is consistent with guideline recommendations, and the medical necessity is established.

**Trazodone 100mg 50mg #60:** Overturned

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

**Decision rationale:** CA MTUS does not address the use of Trazodone. The ODG states that sedating antidepressants have also been used to treat insomnia; however, there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. Trazodone is one of the most commonly prescribed agents for insomnia. This patient has a diagnosis of depression and insomnia. Therefore, the request for trazodone is consistent with guideline recommendations, and the medical necessity is established.

**Continue group therapy for depression and anxiety:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment Page(s): 101-102.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PSYCHOLOGICAL TREATMENT Page(s): 101.

**Decision rationale:** CA MTUS recommends psychological therapy for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders. Initial trial of 3-4 psychotherapy visits over 2 weeks and with evidence of objective functional improvement, a total of up to 6-10 visits over 5-6 weeks. For this patient, medical reports do not identify the prior amount of psychotherapy attended, and does not clearly establish objective functional improvements. Therefore, the medical necessity for an unspecified amount of group psychotherapy is not established.