

Case Number:	CM14-0048289		
Date Assigned:	07/14/2014	Date of Injury:	11/05/2003
Decision Date:	08/28/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	04/16/2014

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 Psychiatry and Neurology, Addiction Medicine, has a subspecialty in Geriatric Psychiatry 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:

Records reviewed include 191 pages of medical and administrative records. The injured worker is a 42 male whose date of injury is 11/05/2003 due to lifting a piece of stone weighing around 50-100 lbs. He sustained a lower back injury. Over the course of his injury he was treated with physical treatments, prescription medications, injections, and ultimately back surgery in 2007 with improvement. Residuals included continued low back/head/jaw pain, anxiety/depression, and erectile difficulties. Low back pain is sharp and radiates to the neck and both feet. He has numbness of both knees and both legs with tingling of the right thigh, both legs and feet. There is a urologic consultation report of 10/18/13 indicating that the patient was diagnosed with sexual dysfunction, urge incontinence frequency urinary, and nocturia. He complained of change in sexual activity, erectile dysfunction, urinary frequency post void dribbling, hesitancy, incomplete voiding, and nocturia. He was prescribed Rapaflo 3mg. In a PR2 of 04/28/14 by Elena Konstat PhD, the patient complains of continued feelings of depression, hopelessness, and helplessness. The patient reported that psychotherapy has helped him cope with these stressors and with the depression and pain. Objective findings indicated that the patient appeared angry and frustrated. Progressive relaxation exercise helped him cope with chronic pain and tensed muscles. Treatment plan continued to be as all of the above plans, whose of CBT sessions and group therapy, psychopharmacology management, and medications including Celexa, Lorazepam, and Cogentin prescribed by the office psychiatrist. His diagnosis has been major depressive disorder, single episode, severe without psychotic features, and pain disorder associated with both psychological features and a generalized medical condition. In a review of 02/10/14 it was recommended that lorazepam be weaned and 2mg #27 was approved. It does not appear that this has been done. Per utilization review of 03/12/14, 6 additional sessions of cognitive behavioral

therapy had been approved through 04/05/14. Medications at the time of this request were Dilaudid 2mg Q8H prn, Celexa 10mg BID, lorazepam 2mg prn, and Cogentin 0.5mg BID. There are a number of other earlier PR2's from pain management specialists and [REDACTED], with this same information.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Cognitive Behavioral Therapy Sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 135. Decision based on Non-MTUS Citation Occupational Disability Guidelines; Cognitive Behavioral Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23 of 127.

Decision rationale: The patient continues to complain of subjective of depression, hopelessness, and helplessness. The patient reported that psychotherapy has helped him cope with these stressors and with the depression and pain. Objective findings indicated that the patient appears angry and frustrated. Although the patient reports that psychotherapy has been helpful, both subjective and objective findings remain consistent throughout [REDACTED] progress notes. He has received approval for an additional 6 sessions of cognitive therapy through 04/05/04. Given that those sessions are already on top of sessions utilized, the patient would have received greater than the 6-10 sessions the 6-10 sessions recommended by MTUS and ODG, and well beyond the recommended 5-6 weeks, again, all without evidence of improvement. As such this request is noncertified. The California-MTUS: Behavioral interventions are recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these at risk patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone: Initial trial of 3-4 psychotherapy visits over 2 weeks, With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions).

12 Group Psychotherapy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 102 of 127.

Decision rationale: The patient continues to complain of subjective of depression, hopelessness, and helplessness. The patient reported that psychotherapy has helped him cope with these

stressors and with the depression and pain. Objective findings indicated that the patient appears angry and frustrated. Although the patient reports that psychotherapy has been helpful, both subjective and objective findings remain consistent throughout ██████████ progress notes. There is no evidence that goals were set or that the patient's psychological and cognitive function was assessed. In addition, He has received approval for an additional 6 sessions of group therapy through 04/05/04. Given that those sessions are already on top of sessions utilized, the patient would have received greater than the 6-10 sessions the 6-10 sessions recommended by MTUS and ODG, and well over the recommended 5-6 weeks, again, all without evidence of improvement. As such this request is noncertified. California-MTUS recommends psychological treatment 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 (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following stepped-care approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.

3 Psycho Pharmacology Management 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; Mental Illness and Stress.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Office visits.

Decision rationale: The patient is on multiple medications for both major depressive disorder and pain management, requiring monitoring for efficacy, and assess for drug-drug interactions and the emergence of side effects. Community standard, and patient safety, dictates that regular medication monitoring by a physician be conducted to insure all of the above. In this patient's case, per ██████████ PR2's, his symptoms of depression, hopelessness, and helplessness, and her objective assessments of the patient of anger and frustration have not shown any signs of improvement. Given this perhaps consideration may be given to, a reassessment of the medication regimen for efficacy, its dosage, appropriateness of this particular agent, and any augmentation strategy that the physician may feel to be helpful in alleviating this patient's symptomatology. As such, this request is medically necessary. The ODG stress related conditions office visits: Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. 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. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. Per ACOEM the frequency of follow-up visits may be determined by the severity of symptoms, whether the patient was referred for further testing and/or psychotherapy, and whether the patient is missing work. These visits allow the physician and patient to reassess all aspects of the stress model (symptoms, demands, coping mechanisms, and other resources) and to reinforce the patient's supports and positive coping mechanisms. Generally, patients with stress-related complaints can be followed by a midlevel practitioner every few days for counseling about coping mechanisms, medication use, activity modifications, and other concerns. These interactions may be conducted either on site or by telephone to avoid interfering with modified- or full-duty work if the patient has returned to work. Follow-up by a physician can occur when a change in duty status is anticipated (modified, increased, or full duty) or at least once a week if the patient is missing work.

Celexa 10 MG: 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: The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines, Major Depressive Disorder.

Decision rationale: The patient carries the diagnosis of major depressive disorder, single episode, severe (296.23). SSRI, of which Celexa belongs, Per the American Psychiatric Association, are the first line choice due to efficacy and low side effect profile. Celexa may also address the patient's psychological symptoms due to pain. However, due to the fact that his subjective and objective symptoms as described in [REDACTED] ongoing progress reports remain unchanged, this medication should be reassessed in the certified psychopharmacology sessions above. As such, this request is medically necessary. The ODG recommends antidepressants for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. Drug selection criteria. The American Psychiatric Association has published the following considerations regarding the various types of antidepressant medications: (1) Many treatment plans start with a category of medication called selective serotonin reuptake inhibitors (SSRIs), because of demonstrated effectiveness and less severe side effects; ODG Formulary, ssri's: It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRIs and pain.

Lorazepam 2 Mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24 of 127.

Decision rationale: The patient is being prescribed lorazepam 2mg prn. There is assessment in the chart for the necessity for this medication. There are no descriptions of any symptoms that would require the use of lorazepam in any dosage (e.g. anxiety etc). Looking at the dates on [REDACTED] progress reports, I see that the patient has been prescribed this medication since at least February 2014, which is well beyond the 4 weeks recommended for use by MTUS and ODG. If the patient had been suffering from an anxiety disorder in addition to his major depressive disorder, MTUS states that a more appropriate treatment for an anxiety disorder would be an antidepressant. The patient is on Celexa, which is an antidepressant of the class SSRI, and has been approved for generalized anxiety disorder. This, or another antidepressant/augmentation medication, could be considered for use in anxiety which would be safer than a benzodiazepine, especially when benzodiazepines are used in combination with pain management medications (in this man's case, Dilaudid). An approval for lorazepam 2mg #27 was given in 02/04/10, it is unknown if this was performed or not. This request is not medically necessary. Per California-MTUS the use of benzodiazepines is 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. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005).

Cogentin 0.5 MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse, American Medical Directors Association, Parkinson's Disease In Long Term Care Settings, 2010, Pg37.

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: Pharmacological treatment of Parkinson disease: a review. JAMA 2014 Apr 23-30. Connolly BS.

Decision rationale: I could not find any reference to an assessment or symptoms to justify the use of Cogentin in this patient. Cogentin is an anticholinergic agent which blocks acetylcholine in the central and peripheral nervous systems. They inhibit involuntary movement of smooth muscles of the GI tract, GU tract, lungs, etc. Cogentin is used mainly in movement disorders such as Parkinsonism and to treat extrapyramidal symptoms occurring as a side effect of certain antipsychotics. The patient is not prescribed any form of antipsychotic, nor does he have Parkinson's disease or any other form of movement disorder described in records. It is not a side effect of Cymbalta. As such this request is not medically necessary. Cogentin is not found in California-MTUS, ODG, or ACOM. Other guidelines were used in the formulation of this decision.